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PREFACE

The Chairman wishes to thank all those involved in the work of the Task Force including Murray Thompson, the Superintendent of Insurance, Deborah Coyne, the Executive Director, and the members of the Policy Advisory Group. The Chairman also wishes to thank all those who undertook research and survey papers for the Task Force, John Moffet and Percy Thadaney for their research assistance, and members of the Freelance Editors' Association of Canada. Their contribution was invaluable and is greatly appreciated.

The Chairman takes full responsibility for the Report and the Recommendations. The Chairman has depended heavily on his advisors and thanks them deeply for their sound counsel. The views expressed in the Report, however, are those of the Chairman and not necessarily those of his advisors.

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EXECUTIVE SUMMARY AND OVERVIEW

Terms of Reference of the Task Force

The Task Force on Insurance was appointed on January 9, 1986, by the Minister of Consumer and Commercial Relations and given a broad mandate to seek out "solutions for cost and capacity problems in the property and casualty insurance industry in Ontario". More specifically, the Task Force was directed to explore "all possible approaches to such solutions which have the result of creating, on a long-term basis, increased market stability, policyholder protection and a climate of economic opportunity for insurance companies in Ontario". These possible approaches include:

- stricter entry requirements for insurance companies;
- provisions for ensuring that companies have a long-term commitment to the Ontario market;
- modernization of investment rules for insurance companies;
- introduction of higher duties and responsibilities for directors and management;
- rules controlling self-dealing;
- provisions for greater control over the obtaining of reinsurance;
- government-run insurance;
- creation of greater market discipline in the placing and buying of insurance, including greater elements of disclosure;
- modification of insurance rating practices;
- rate control of premiums;
- introduction of prudential rules and regulatory tools to ensure financial soundness of insurance companies;
- elements of cost control over non-economic loss in liability cases;
- no-fault insurance;
- updating rule of corporate governance, with a view to similarity with the Ontario *Business Corporations Act, 1982*;
- equal application of rules for the insurance business to all companies operating in Ontario;
- stronger role for auditors, audit committees and actuaries;
- promotion of various forms of reciprocal insurance;
- introduction of rules for prudent underwriting and risk-analysis practices.

The Task Force has interpreted the reference to property and casualty insurance to include the whole field of general insurance with the exclusion of health and accident insurance.

Background

The establishment of the Task Force was prompted by the clear perception on the part of the government that Ontario is experiencing an acute insurance crisis that is having a significant and far-reaching impact on all sectors of the Ontario economy and society. Although most observers agree that the industry is prone to cyclical movements in capacity and prices, it is all too evident that the magnitude and severity of this particular cycle had taken everyone by surprise.

As consumers face huge increases in premiums and in some cases the total withdrawal of capacity, there has been no lack of accusations, counter-accusations, finger-pointing and anecdotal explanations. On the one hand, Ralph Nader and the National Insurance Consumers Organization in the United States, supported by both American and Canadian trial lawyers, argue that the crisis is a scam produced by greedy insurers who are in fact making a great deal of profit in the current market. Others focus on poor management and excessive hysteria within the industry.

For their part, primary insurers blame the crisis on high court awards and so-called "judicial inflation" within the tort liability system. Increased consumer consciousness with respect to insurance claims, together with the withdrawal of reinsurance, are two other related explanations.

Reinsurers likewise blame judicial inflation but also point the finger back at the primary insurers for pursuing the destructive course of cash-flow underwriting during the heady days of high interest rates, and for failing to retain sufficient amounts of risk. According to this argument, the name of the game became the maximization of market share, while letting investment gains offset underwriting losses. Then when interest rates fell precipitously and investment income declined at the same time as claims were rising significantly in terms of both frequency and size, premium income and reserves suddenly proved woefully inadequate. Reinsurers were called upon to pay the large losses incurred by the smaller insurers in particular, while simultaneously suffering in their international operations from a seemingly relentless series of catastrophes from Bhophal to earthquakes to the *Achille Lauro*.

Governments and regulators, like the insurance industry, have also received their share of the blame. Everyone has at some stage stressed the failure of public authorities to ensure the solvency and liquidity of insurers (witness the recent insolvencies of five insurance companies), to control rates, and to protect consumers adequately. Remedial suggestions have run the gamut from the creation of a government insurance corporation to minor regulatory tinkering.

Needless to say, the confusion that emerges from the barrage of sometimes conflicting explanations is not easily dispelled, nor are the prescriptions for reform easily identified. Regardless of the precise analysis and conclusions, one conclusion is inevitable: any market that gives rise to the tremendous swings in premium levels and withdrawal in capacity that we have witnessed is simply not operating soundly. Furthermore, although the insurance industry is clearly struggling to respond adequately to the intense internal and external pressures, it does not appear to be able at present to ensure stability in the insurance product.

Task Force Activities

Despite the limitations created by the Task Force's obligation to report in three months, it has sought the views of a wide range of individuals and groups in an attempt to analyze the source of the crisis, and formulate effective recommendations for change. First, a Policy Advisory Group was established that was designed to bring together a variety of persons with expertise in such key areas as insurance, law, accounting, economics and actuarial science. Second, a systematic effort was made to contact certain persons and groups and, more broadly, to solicit the views of any concerned and interested persons on matters relating to the Task Force's mandate. Well over 200 briefs and submissions were received and reviewed by the Task Force, and a substantial number of consultative meetings took place.

This consultation process was extremely useful in identifying the critical problems and possible solutions, and has proved invaluable in formulating the final recommendations of the Report. It should be emphasized that the Task Force has enjoyed the full co-operation of a great number of persons, whether from the insurance industry, the legal profession or insureds themselves. Clearly this greatly facilitated the consultations and permitted the Task Force to proceed expeditiously and constructively at all times.

At the same time, the Task Force was linked to two Inter-Ministerial Advisory Groups established under the Ministry of Consumer and Commercial Relations, as well as the Market Assistance Program and Hot-Line assistance service. As a result, the Task Force was aware of the broad range of concerns confronting the government and the more critical and intractable aspects of the insurance crunch raised by the public.

It was not possible in the short time available to undertake new research. Nevertheless, at an early date, the Task Force commissioned a number of papers and memoranda on various general insurance industry developments and issues. While intended initially as primarily survey and evaluative papers rather than as research papers, many of them bring into focus the accumulated wisdom on key issues and a considered judgment on current and future issues and concerns. Arrangements have been made with the authors for the submission of the work in the public record of the Task Force. These are listed in Appendix 2 of this Report.

In approaching its work, the Task Force has at all times focused on the concerns of the insured consumer and the overriding interest in the availability of adequate and affordable insurance. At the same time, while it has been important to analyze the experiences of other Canadian jurisdictions where the government has directly entered the insurance business, the Task Force has sought solutions within the framework of a private insurance industry that operates effectively, efficiently and fairly from the point of view of the consumer. Finally, the Task Force should emphasize that its investigation of insurance has involved a strong emphasis on the means of enhancing the control of risk and the reduction of losses, as well as simply insuring against risk.

Analyzing the Crisis

The current crisis has highlighted the fact that adequate insurance coverage is essential to the ordinary Canadian, and that the public has a pressing interest in both a stable risk environment and a stable insurance product. Insurance permits the individual to cope with future uncertainties by pooling the risk of loss. It permits commercial entities to carry on business in an environment more conducive to economic growth and expansion. The loss of a home or business premise would be a devastating event in the absence of insurance, and major new investments might not be made without the capability of insuring risk. Certainly, a reduction in risk taking would have far-reaching social and economic consequences for our standard of living, as well as significant individual consequences. Yet surprising as it may seem, the general public is only now realizing that the insurance industry is an essential multi-billion-dollar-a-year component of the financial services industry, and of our economic infrastructure, as well as a critical element in our social and economic lives.

The general insurance industry is one in which there has clearly evolved a mix of state/government and market mechanisms, and the need for a government presence in regulating and supervising the provision and availability of insurance has long been accepted. The basis of this government presence varies and is by no means limited to situations of so-called "market failure" when the private industry is unable to fulfil some essential functions efficiently. Rather the government interest extends to active measures to reduce the probability of loss, to promote the stability of the insurance industry and to facilitate the pooling of risk and uncertainty.

In investigating the causes of the current instability in the insurance market and the extensive cost and capacity problems, the Task Force has been severely hampered by the lack of empirical evidence and data necessary to support or reject a particular theory. Despite some improvements in industry data bases in particular, there is still little meaningful evidence with respect to many critical matters. These include the cost components of bodily injury claims, both automobile and non-automobile, and data on the financial, operational and administrative performance of insurers that would permit a meaningful comparative assessment by the consumer. The Task Force was able to undertake some limited research into data on court awards and settlements, but emphasizes the need for all concerned to undertake more empirical research and quantitative analysis on a much more systematic basis.

In approaching the analysis of the causes of the crisis, the Task Force began first by focusing on the structure of the industry and the cyclical features of the market. This analysis is set out in Part A. The dominant conclusion that the Task Force has reached is that the crisis does not reflect simply a more severe and unusual cycle of activity which is in the process of being corrected through adjustments in prices and premiums. Rather, the crisis reflects serious socio-legal and economic changes of a structural nature that give rise to such a degree of uncertainty as to permanently alter the risk environment and the insurance market. Thus, certain fundamental reforms to the system are required in order to stabilize the risk environment and ensure the provision of available, affordable and adequate insurance.

More specifically, although as Part A indicates, the financial performance of the industry in the aggregate is basically sound, and there is adequate capacity to meet the demand for insurance generally, there are particular areas, notably liability insurance, in which the losses (excess of claims over premiums) have been extreme and the reduction of the capacity is most critical. The climate surrounding such risks has simply become so threatening that insurers refuse to underwrite on the grounds that they are no longer pooling risks but are in effect assuming the risk.

The structural changes that give rise to such extreme unpredictability and the marked increase in frequency and size of claims are threefold. Firstly, individuals in today's technologically advanced, post-industrial society are being exposed to a growing array of risks and hazards, many of which are highly indeterminate and long range, for example, the as-yet-undetermined effect of environmental pollution or various complex chemical and biological products and processes.

Secondly, concurrent with the proliferation of the risk facing the public and with the widespread availability of general liability insurance, the contemporary insured is far more conscious as a consumer and more inclined to seek compensation for a wide variety of losses.

Thirdly, the pressure to compensate, particularly in the personal injury area, has resulted in a virtual explosion in liability and liability litigation. The law of negligence is being judicially expended and extended to new areas of activity and injury. Courts are certainly at the forefront of these changes, but the driving force behind these changes, and in large part the cause of the "crisis", is the very existence of liability insurance. The phenomenon of modern liability insurance has played a major role in transforming tort and in creating a judicial environment that is becoming increasingly uncertain and unpredictable.

The identification of these structural changes is critical to an evaluation of the assertions that court awards and settlements are escalating out of control and that Ontario is becoming "California North". The Task Force has studied this matter with care, and its analysis is set out in Part B. Much of the current criticism that is being levelled at the court system is rooted in a fundamental misunderstanding of Canadian tort law and how it differs from that of the United States. However, even given these important differences, the Task Force has concluded that the most that can be said is that Ontario is not "California North" — yet. Notwithstanding the formal differences between the American and Canadian tort systems, the structural similarities are more significant and will ensure continuing uncertainty and unpredictability both in the United States *and* in Canada.

It is necessary to emphasize that the Task Force is not suggesting the court system or the judges be blamed for the current crisis. Rather it must be recognized that the courts are simply reflecting the deep social, legal and economic changes that have fundamentally altered the risk environment. The courts have responded effectively and with compassion to demands for compensation in the limited situations in which are permitted. The basic problem in the realm of personal injury liability is not any failure of the judiciary to compensate adequately where the law permits compensation. As is explained more fully in Part B, the problem is more systemic: the profound inequity and unpredictability in continuing to use tort as a mechanism for accident compensation.

The Task Force has therefore concluded that, at least in the personal injury area, fundamental reform to the relationship between tort/litigation and the insurance system is required. Accordingly, the Task Force recommends that steps be taken toward implementing a fundamentally different system of personal injury compensation – first in respect of automobile accidents, but eventually in respect of all accidents. The design of the system will entail the introduction of a system of mandatory first-party insurance coverage set at such levels as to cover the majority of Ontario citizens, together with firm initiatives to enhance the deterrence to hazardous driving such as by means of a bonus-malus penalty rating system. Recommendations for a substantial no-tort system will also be put forward as an alternative.

The Task Force recognizes that many thoughtful proposals have been put forward to reform the tort system in order to enhance its equity and efficiency and assist in improving the effectiveness of the overall insurance system. As set out in Part B, these proposals must be seriously considered and implemented where appropriate. But the Task Force does not believe that these reforms, while valuable in themselves, will address sufficiently the long-term structural changes that are at the root of the extreme uncertainty confronting the insurance industry.

Enhancing the Availability, Affordability and Adequacy of Insurance

In addition to the systemic changes proposed in respect of personal injury compensation, the Task Force has put forward a number of recommendations designed to enhance the availability and affordability of liability insurance. These include proposals in respect of such mechanisms as reciprocal insurance exchanges, self-insurance, insurance pools and the insurance exchange. One important proposal is for an export liability insurance pool to deal with the particularly difficult problems faced by exporters to the United States. All of these proposals require little or no legislative change.

Recommendations are also made in respect of the new claims-made form of insurance policy that has been developed by the insurance industry to help limit long-tail exposures. Given the serious implications of the new form of insurance for potential gaps in and adequacy of coverage, the Task Force believes that the regulators must monitor the situation.

The Task Force has also addressed the need to improve the efficiency of the insurance system and the quality of services provided to the insured. Recommendations to improve the distribution system and reduce the all-too-substantial transactions costs are set out in Part C. These include proposals to improve communications between insureds, brokers and insurers, and to implement changes in the commission rate structure.

Finally, in Part D, the Task Force addresses the need for improved financial regulation and market regulation. Financial regulation refers to the controls placed on the structure of insurers, the financial aspects of their operations and their accountability for such operations. Market regulation refers to the control placed on the relationship between insurers and insureds and their respective rights and obligations, including contracts of insurance, policies, rates, premiums and insurance delivery networks.

The Task Force makes a number of recommendations in Part D with respect to the capital and surplus requirements of insurers and the financial activities of insurers, including investments, reinsurance, reserves, disclosure of information and certain taxation matters. The Task Force views the establishment of a policyholder compensation fund, in which all property and casualty insurers doing business in Ontario would be required to be members as a condition of licencing, as an important government-industry initiative.

The Task Force concludes in Part D that the system of delivering insurance products to the consumer can be improved through specific communication and education mechanisms, particularly with respect to the encouragement of increased risk management. Specific recommendations address the need for agents/brokers to give timely notification to insureds of changes in price, coverage, exclusions and non-renewal.

The Task Force does not recommend the introduction of rate regulation, although it does favour a more systematic framework for the monitoring, surveillance and evaluation of rates. The Task Force also makes suggestions as to how governments may usefully become more involved in property and casualty insurance.

As already noted, the Task Force believes that there is no evidence of any need for the Government of Ontario itself to participate directly in the insurance business. With enhanced regulation to ensure the financial stability of the industry, and an equitable and efficient market for the insurance product, there is every indication that the private insurance industry will be able to provide high-quality and reliable service to the consumer.

In conclusion, the Task Force has put forward a wide range of recommendations designed to address the cost and capacity problems in the insurance market. Since the primary cause of these problems is fundamental socio-legal and economic changes, some of the recommendations involve reform to the very nature of the insurance system itself with respect to personal injury compensation. Other recommendations are directed at changes within the system designed to enhance capacity in the more intractable areas of liability insurance, to improve the efficiency and equity of the system, and to eliminate the high degree of instability in the general insurance market.

PART A

THE INSURANCE CRISIS: STRUCTURAL OR CYCLICAL?

PART A

THE INSURANCE CRISIS: STRUCTURAL OR CYCLICAL?

I INTRODUCTION

The current insurance crisis has had a significant and far-reaching impact on the Ontario economy and society. In this Part the Task Force examines the sources of this crisis.

Traditional analysis explains the performance of the insurance industry as a cyclical phenomenon, manifested by ebbs and flows in capacity and prices. However, it is now clear that the so-called "Eighth Cycle" cannot be fully explained within the standard framework of analysis that has been applied to previous cycles. The Task Force has therefore concluded that while the cyclical forces inherent in the insurance industry will eventually ameliorate the current situation, simple adjustments to prices and premiums will not completely resolve the problem.

To view the current situation as yet another cycle is inappropriate and would lead to ineffective prescriptions for change. Instead, it must be recognized that the current crisis reflects major technological, social, legal and economic changes that have so fundamentally affected the risk environment and the insurance market that it is no longer possible for the current cost and capacity problems to be overcome within the parameters of the existing system.

In this Part we examine the factors that have so destabilized the current risk environment. This examination is followed by an assessment of the insurance industry's current financial situation and its prospects for the immediate future. The above analyses are intended to identify precisely the characteristics and sources of the current crisis. This, then, will facilitate the more specific analyses and recommendations contained in Parts B, C and D.

II KEY SOCIO-LEGAL CHARACTERISTICS OF THE INSURANCE CRISIS

The Changing Risk Environment

As noted above, it is the opinion of the Task Force that the source of the current insurance crisis is primarily the fundamental changes in the risk environment to which the insurance industry in its current form has failed to respond adequately. These changes are basically threefold:

(1) the impact of technology;
(2) concurrent changes in the public attitude and expectations vis-à-vis risk and compensation; and
(3) the judicial response to the above two factors.

The Impact of Technology

In today's technologically advanced, post-industrial society, people are being exposed to a growing array of risks and hazards, many of which are highly indeterminate and long range in nature. This development is significant not only because the number of insurable risks is expanding, but also because modern technology has created an environment of uncertainty and unpredictability. For example, the as-yet-undetermined effects of environmental pollution or of various complex chemical and biological products and processes not only demand new insurance products, but also bring into serious question the ability of the industry to even respond to those demands.

Public Attitude and Expectations

Concurrent with the proliferation of the risks facing the public and with the widespread availability of general liability insurance, the contemporary insured is far more "consumer conscious" and more inclined to seek compensation in respect of a wide variety of losses.

This development has underlined the fact that the main function of insurance is to provide compensation. The pressure to compensate has been focused on the insurance industry, on the government and on the judicial system, and has altered and destabilized the traditional "demand" parameters of the insurance analysis.

The Judicial Response

This pressure to compensate, particularly in the personal injury area, has resulted in a virtual explosion in liability and liability litigation. The situation in Canada has not reached American proportions, largely because of a number of important differences, which are explained more fully in Part B. The differences between the two systems, however, are differences in degree, not differences in kind. The underlying causes of the continuing expansion of liability to new areas of activity and injury are fundamentally similar, and relate in large measure to the role that liability insurance has played in the transformation of the tort system.

This transformation, described in detail in Part B, has placed the courts in a difficult if not impossible position, and has created a judicial environment that is becoming increasingly uncertain and unpredictable.

Conclusion

The current crisis arose because of a conjuncture of the traditional cyclical factors relating to price and capacity, together with the cumulative impact of longer-term structural changes arising from an increasing focus on compensation; heightened consumer expectations; greater exposure to risk and hazards; and so forth. Each of these additional factors has the effect of injecting another layer of uncertainty into the risk environment. This uncertainty is exacerbated by the judicial response in the area of personal injury compensation.

Two initial conclusions can be drawn from the above analysis. The first is that in the area of personal injury compensation certain fundamental systemic reforms are advisable. This area is more fully considered in Part B, in which it will be proposed that the government establish a no-tort system of personal injury compensation, first in respect of automobile-related accidents, but eventually in respect of all accidental injuries.

The second conclusion is that it will not be possible to overcome the present crisis with solutions designed only to address its cyclical features. Rather, we must address ourselves directly to the significance of the added element of uncertainty that the above factors have added to the industry.

The Significance of Uncertainty

In a paper prepared for the Task Force, Mathewson and Winter review the main grounds on which property and casualty insurance differ from other market-based goods.[1] They emphasize that the most important difference is the contingent nature of the insurance contract. At the time of the sale of the insurance contract the potential liability assumed by the insurer is in the future and is therefore necessarily indeterminate. The magnitude of the risk assumed by the insurer depends on the degree to which the probability of the occurrence of the potential liability being insured against can be accurately predicted.

> These risks are, of course, exacerbated when insurers cannot forecast the nature of anticipated potential liabilities; these risks are further exacerbated when the actions of those insured can influence the likelihood of states where losses occur (moral hazard), or when insurers have incomplete information on the risks that they insure (adverse selection).

The changes in the risk environment have impacted on the contingency element of the insurance industry in two ways. First, the industry is being forced to meet obligations today that may have had their genesis years ago, in a fledgling technology, unbeknownst to insurer and insured alike (e.g., asbestosis). Second, and more important, the uncertainty that is already inherent in the insurance product has been enhanced in the contemporary environment.

As the Mathewson and Winter paper indicates,[2] the basic effect of any significant increase in the level of uncertainty in the insurance industry is precisely what is being experienced now: significant increases in the price of insurance together with industry-wide retrenchment in underwriting.

As the economic analysis summarized below indicates, paradoxically the present reaction to the increased uncertainty in the industry will most probably result in some short-term recovery by improving the capital base and by returning the cost-profit ratio of the industry closer to its equilibrium point. However, as the economic analysis also indicates, exclusive reliance on the cyclical improvements in the short-term situation would be unlikely to address the endemic problems that face the industry today.

III KEY ECONOMIC AND FINANCIAL CHARACTERISTICS OF THE INSURANCE CRISIS

Macro-Analysis

Supply and Demand

The demand for insurance is relatively inelastic. Insurance requirements pervade modern life. Automobile insurance is now a compulsory, essential adjunct of driving. Governments, banks and many non-financial businesses routinely require transactions to be insured as a precondition to the transactions themselves. Property insurance is a precondition of obtaining a mortgage on a house. And farm produce cannot be moved from elevator to seaboard unless the carrier has insurance. Indeed, not only is the range of mandatory insurance legislation expanding as set out in Appendix 6, but the demand for new and different forms of insurance by the Canadian consumer continues to expand steadily.

As in most activities, there is no "free lunch" in insurance. As the public demands higher compensation, and as the risks associated with modern life escalate in degree and uncertainty, the insurance industry must respond by charging higher premiums. Of course the pricing of insurance is based on many factors, such as transactions costs, investment income and the capital base. Nonetheless, the fundamental price factor is the relationship between claims paid and premiums received.

The rapidly changing demand factors that have helped precipitate the current crisis have been reviewed above. In reviewing the supply factors, it must be emphasized that some supply characteristics are similar for all market-driven structures, while others depend on whether the structure is highly competitive or has strong elements of monopoly or conspiratorial structures.

In North America the supply of insurance is provided mainly by private-sector bodies, including co-ops, mutuals and joint stock companies. To a considerable extent, the private suppliers have to be able to evaluate the contingencies inherent in the insurance contracts they supply, as well as their cost of operation. They must also, over the long run, earn at least a competitive rate of return on the capital employed. They must cope for a time with the risks of bankruptcy arising from actual claims exceeding the expected value of claims by a significant margin. They must also be innovative as social and technological conditions change.

The consensus of industrial organization scholars who have examined the structure of the general insurance industry in North America is that the supply side of the market is essentially competitive in nature.[3] Entry and exit are easy, both for domestically chartered and foreign chartered insurance firms. Economies of scale and scope are not significant. As a result, the insurance market should be efficient and responsive. As a long-run equilibrium matter, such a market structure is expected, subject to some qualifications with respect to information, moral hazard and adverse risk selection, to yield approximately efficient results in the sense that costs should be minimized and the price of the service should equal the costs — including opportunity costs — of capital employed. If more expensive services are demanded, premiums should increase in the long run in line with the increased actuarial value of the benefits together with any increases in transaction costs.

The current pricing experience, especially in the realm of personal liability insurance, has necessitated a re-evaluation of the above basic traditional assumptions.

In their paper, Mathewson and Winter address the issue of whether the competitive model is still viable in light of the observation that recent increases in premiums and reductions of coverage do not reflect the historical record of costs. They argue that increases in the average level of awards and settlements, together with the sort of increased socio-legal uncertainty in the risk environment described by Professor Trebilcock[4] will typically lead to short-run increases in prices of insurance services that are larger than the increases in coverage costs incurred by the industry. They argue that as uncertainty is replaced by greater certainty over time, the long-run competitive market efficiencies should re-emerge. Thus, premiums will ultimately again be determined mainly by claims and transaction costs.

The papers prepared by Mathewson and Winter and by Trebilcock both reaffirm the conclusion that the insurance industry is essentially competitive. However, both papers emphasize that the unusual nature of the insurance product, together with the growing uncertainty associated with the modern risk environment, necessitate an unusual adjustment process for a competitive industry. To understand the nature of this adjustment process it is first important to understand the cyclical nature of the insurance industry.

The Insurance Cycle

While the Task Force has concluded that the current crisis is structurally different from previous cycles, the cycle analysis does provide a perspective from which the true gravity of the current situation can be appreciated. In addition, an understanding of the cycle analysis enables one to recognize the basic distinctions between the current situation and the past.

The cyclical experience is set out in a survey paper prepared for the Task Force, included in this report as Appendix 7. That paper is based on more detailed papers listed in the Appendices, and on the many submissions to the Task Force. Only the main arguments and conclusions will be presented here.

The typical features of the insurance cycle can be summarized as follows:

If one starts from a situation of overcapacity in which there is surplus capital against which to write insurance, availability will be high and extended coverages will be offered at lower prices. Self-insurance will shrink as insureds take advantage of the situation to reduce their deductibles. Similarly the incentive to promote risk limitation will be reduced. Generally, this cycle will coincide with a strong economy. Each firm will thus attempt to maximize its market share by underwriting its cash flow. Eventually, the equilibrium price-cost relationship for the industry will be undershot as potential loss and expense levels overtake premium and investment incomes. Capital and surplus will then deteriorate; firms will withdraw or fail; and retrenchment will start to take place, manifested by higher prices, reduced availability, more selective risk-insuring, and reduced adequacy of coverage. This will lead to cancellation and non-renewal of contracts.

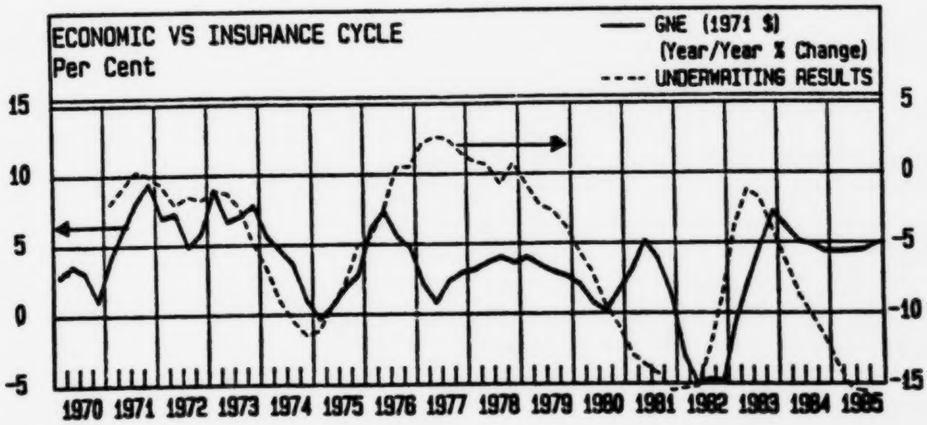
Ultimately, higher prices and lower expenses will create better loss ratios and a reduction in reserve requirements, thereby increasing industry profitability. The new entrants attracted to the market together with the increased surplus capital will generate lower prices and increased availability. The equilibrium price-cost position on the high price side will then typically be overshot, and overcapacity will develop. The cycle is then complete.

Reinsurance will usually be dragged along by the cycles in first-line insurance. However, independent factors in the availability of capital, profit evaluation or costs of reinsurance can exercise their own distinctive influences on the overall cycle.

A summary view of the current and some recent cycles in the property-casualty insurance industry is presented in Charts 1 and 2. The insurance cycle is effectively indicated by developments in the underwriting results (defined as net premium income less the sum of net claims incurred and expenses and dividends as a per cent of net premium income). If this ratio is −10%, for example, an underwriting loss equal to 10% of the premium income has occurred (i.e., net claims incurred and expenses and dividends have exceeded premium income by 10%). The profitability of the industry may still be positive because investment income might be equal to 15% of premium income.

Chart 1 shows a trough of underwriting loss in 1974-1975, followed by a peak of underwriting profit in 1977. This was followed by a trough in 1981-1982; an unusually short cycle peak in 1983; and a trough of severe losses in 1985. Except for the unusually favourable underwriting profit of 1983, the last five years are an exceptionally long and severe period of underwriting losses. The insurance cycle is quite distinct from the economic cycle, although for obvious reasons economic cycles do have some influence on the specific shape of insurance cycles.

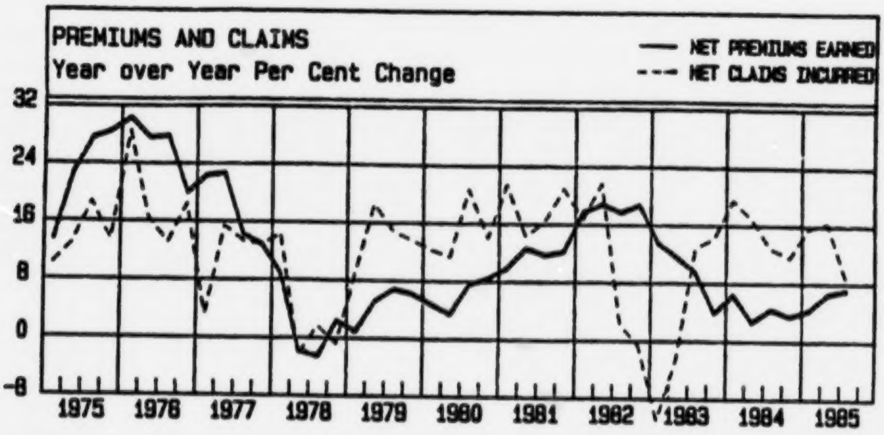
CHART 1



Source: *Statistics Canada, Financial Institutions*, Cat. No. 61-006 and *National Income and Expenditure Accounts*, Cat. No. 13.001.

Chart 2 shows that the insurance cycle is mainly due to variations in the rate of growth over time in net premiums earned, rather than cycles in the net claims incurred. Year-to-year changes do take place in net claims incurred but these are, broadly speaking, random rather than cyclical. Chart 2 also shows that, except for the anomaly centring on early 1983, the annual growth rate in net claims incurred has been greater than the average growth rate in net premiums earned. It should also be noted that there has been no trend of acceleration or deceleration (i.e., increase or decrease in the rate of increase) in the total dollar amounts for net claims incurred over the recent past.

CHART 2



Source: Statistics Canada, Financial Institutions, Cat. No. 61-006.

Table 1 presents property-casualty results for eight years ending in 1985. In interpreting these results, two caveats are important. First, the results of government insurance corporations are not included; their operations would account for more than $2 billion of net premiums earned in 1985. Second, net claims incurred includes additions to claims in reserve made during a given year in anticipation of expected future claims payments.

The table shows several important features of the current insurance cycle. First, 1985 was the worst year of the last eight in underwriting loss, at $1,260 million. However, it was also the best year ever in investment income, at $1,350 million, not including extraordinary transactions. Extraordinary transactions — mainly realized capital gains on the sales of securities — yielded another $279 million, and contributed to an overall profit of $386 million for the industry. The bull market in stocks and the increased prices of outstanding bonds due to the fall of interest rates during 1985 created unusual capital gains, some of which were realized by the industry and would be included in the extraordinary transactions.

Second, during the last five years the compound annual growth rate in net claims incurred has been near 12% per year, compared with a comparable growth rate of premiums earned at about 10% a year. Between 1984 and 1985, however, net claims incurred increased by 13.8%, while net premiums earned increased by only 7.7%.

TABLE 1
PROPERTY/CASUALTY INSURANCE INDUSTRY RESULTS
($ MILLIONS)

	1978	1979	1980	1981	1982	1983	1984	1985
Net Premiums Written	4,643	4,970	5,328	6,028	7,056	7,456	7,724	8,738
Net Premiums Earned	4,560	4,813	5,102	5,690	6,723	7,341	7,639	8,225
Net Claims Incurred	2,977	3,390	3,887	4,607	5,019	5,198	5,966	6,790
Loss Ratio	64.7	70.4	76.2	81.0	74.7	70.8	78.1	82.5
Expenses & Dividends	1,594	1,616	1,788	1,973	2,266	2,471	2,590	2,695
Expense Ratio	34.7	33.6	35.0	34.7	33.7	33.7	33.9	32.8
Underwriting Profit/Loss	28	(192)	(572)	(889)	(562)	(328)	(917)	(1,260)
Combined Ratio	99.4	104.0	111.2	115.6	108.4	104.5	112.0	115.3
Insurance Operations Investment Income	339	408	455	545	602	655	734	790
Insurance Operations Profit/Loss	367	216	(116)	(344)	40	327	(182)	(470)
Other Investment Income (Equity)	243	293	327	391	452	464	521	560
Income Taxes & Extraordinary Transactions	(168)	(109)	1	113	(37)	(51)	23	292
TOTAL NET INCOME	442	400	212	160	455	740	362	383
Income Ratio	9.7	8.3	4.1	2.8	6.8	10.1	4.7	4.7

Note: All ratios shown are a percentage to net premiums earned.
Source: Statistics Canada, Financial Institutions.

Third, a broad judgment can be made about the affordability of property-casualty insurance in the aggregate on the basis of premiums as a percentage of nominal Gross National Expenditure (GNE). Between 1980 and 1985, the burden of insurance costs increased slightly for the Canadian people, from 1.71% to 1.81%.

It has to be conceded that every insurance cycle has its own distinctive features. Also, while the insurance cycle is distinct from general economic cycles, there are interactions between the general economic cycles and the insurance cycles. Nevertheless, the model insurance cycle summarized above appears to be a major cause of the current instability in general insurance.

The fundamental question that derives from the recognition of the cyclical nature of the insurance industry is: why does each cycle appear to be characterized by a "recognition lag"? Why is the industry slow to perceive changes in price-cost-loss, in profit cycles and in prospects?

This analysis then generates an additional set of questions. For example, it may be that there is no critical lag at the industry level, but that for some reason individual firms perceive their position and prospects differently from the industry position and therefore lag behind the industry recognition of the problem. If this is so, is it because of diversity within the industry or because of some more fundamental characteristic of the insurance product? In addition, why are actions so discrete and occasional, compared with the continual and incremental changes that characterize most other financial services? What are the patterns of diversity among firms that appear in the process of overall industry adjustment? Do these influence the shape and efficiency of the process?

The Task Force has also considered the additional delay that occurs after action is taken to change the price and availability of insurance services, but before the financial position of the industry reflects those actions.

Finally, the Task Force has considered the current and potential role of rating bureaus, industry associations, financial market analysts, and regulators in influencing these adjustment processes. Would the process and results be quite different if the structure was substantially monopolized or cartelized rather than competitive? Price-regulated, though competitive?

Analysis done for the Task Force indicates that the combination of the competitive structure of the property and casualty insurance industry, together with the extended time-horizons of the contingent contracts that are the heart of the insurance service, and the inevitability that the actual experience for firms from time to time will diverge significantly from expectation, implies that a measure of market instability is an inevitable and continuous feature of the business. But the analysis also suggests that the current instability is excessive, and could be reduced within the framework of a competitive market structure.

The recognition lag is due in part to the gaps and untimeliness in the availability of relevant data, particularly on court awards and settlements, on claims development, on various elements of costs, and for various kinds of insurance lines on both an aggregated and disaggregated basis. As well, there are notorious gaps in the information available about the underlying elements of processes that determine the size and nature of claims paid. Because there are so few listed stocks of property and casualty insurers in Canada and so thin a market in these equities, the investment community does little research and evaluation on general insurance companies. Canada is much worse off than the United States in this respect. In addition, little scholarly research is done in Canada on insurance subjects. Similarly, few economic and financial journalists have shown interest in the subject.

The Task Force has also concluded that there is a distinct lag in action behind recognition. Even after a number of observers pointed in late 1984 and early 1985 to incipient hard market conditions, little action was taken by insurers, insureds and brokers and agents until late 1985 and early 1986. A primary explanation for this lag is the diversity of positions of individual firms within the industry, together with a worry about the serious consequences of being the first firm to raise prices or retrench. Losing market share and incurring the costs of rebuilding market share later are widespread deterrents to an individual firm considering increasing prices and reducing availability of general insurance early in a cycle. Decision-makers in the insurance industry are more often optimistic than pessimistic. When this optimism is combined with the time-horizons of the contingent contracts, putting off to tomorrow the unwelcome decision to increase price is a seductive alternative.

Finally, a third time lag draws out the cycle. A significant delay is generally experienced between implementation and the decision to change the price and availability of insurance. This delay is explained by the heavy dependence on brokers and agents, and by the use of rate manuals as the vehicles for pricing contracts. It inevitably takes time for the translation of decisions into new pricing and availability guides, and then again for the brokers and agents to put those into use. A bank can change its interest rate daily if it wishes, but property and casualty insurance companies in Canada work with systems that entrench a good deal of inertia. The new rates become effective only on renewals and when new business is written. Renewals are scheduled throughout any given year. In addition, remittances from brokers and agents to insurers are subject to a lag.

The threefold time lag in responding to the demands of the insurance cycle explains in part why the effect of the down-cycle is felt so deeply. The delay in response manifests itself in a number of ways. First, the recognition delay means that the industry does not respond until the situation is poor. When sufficient companies have crossed the threshold of prospective — or actual — serious difficulty, the price increases that result are often abrupt and disproportionate to the actual situation.

In addition, reaction to a down-cycle can be exacerbated by the large shifts of mood that can accompany any major industry change. The potentially disruptive effect of distorted perception from within the industry is heightened in insurance because of the much greater role of uncertainty in the business.

Similarly, because the insurance industry is unable to effectively respond internally to down-cycles, it is also unable to control or influence public perception — which, in turn, may exacerbate the problem. For example, when the American public became aware of the massive increases in potential liabilities associated with asbestosis, the claims made by businesses on their insurers escalated by an order of magnitude that was, at the time, unable to be accurately specified. Once people became alarmed over these developments, the uncertainty that then attached to other related product liabilities and to medical malpractice costs was huge and became increasingly difficult to transform into insurable risks, because little hard data existed on which to confidently base premium rates. Canada has experienced the same sort of concern over escalating awards and settlements for liability. And similarly, it has proved almost impossible to allay these concerns and expectations because so little hard evidence has been gathered and analyzed.

The above conclusions are bolstered by comparisons across lines of insurance. Where there are large bodies of quantitative experience, long histories of good-quality industry analysis, clear indications of both micro-level and macro-level experience, good records of use of reinsurance, and no massive shifts in uncertainty, few surprises are found. Adjustments for the personal lines of automobile and property insurance show these characteristics. These lines are not completely free of problems, nor from instability — the open-endedness in compensation for bodily injury has inevitably influenced them — but comparatively speaking, the degree of instability is not large. However, when one turns to insurance lines characterized by high uncertainty, such as product liability, medical malpractice, and environmental and pollution damage, the shifts in uncertainty and the paucity of hard evidence have given rise to massive instabilities in premiums, availability, adequacy and affordability.

Proposals for the Amelioration of the Effects of the Insurance Cycle

The above analysis indicates that the most important factor required to improve the efficiency of adjustment within the insurance industry is the improvement of the supply and analysis of information about the industry itself.

Industry data-gathering, information, analysis, research, rating and risk management organizations have existed in the fields of property and casualty insurance services for a long time. However, they are somewhat inhibited in their activities lest they be treated as acting to restrain competition, which is illegal under the *Combines Investigation Act*. The industry associations have provided hard evidence and good analysis for a long time on many subjects. However, there are gaps that, if filled, would significantly reduce the current instability, and would improve the industry ability to respond to ongoing structural demands.

Members of the industry associations have been proprietary regarding some crucial elements of information, including awards and settlements, claims development, claims reserves and the details of the underpinning to these elements. Proprietary restraints have also affected the availability of critical industry information on risk retention and reinsurance activities. In neither of these broad areas is information on individual companies required; industry data with some sub-classifications would suffice. To some extent the paucity of information reflects a judgment that the data would not be worth the cost of collection and analysis. In the light of recent experience this appears to be a short-sighted view.

Improved information about awards and settlements, the frequency of claims, and the social patterns and costs of the adjudication process are required to improve industry management. Improved information would also assist market development; the reinsurance process; lawmaking and regulation; and would enable us to demonstrate that Ontario is not "California of the North", and thereby placate the mounting public concerns about a legal and compensation system grown out of control.

In addition, more systematic and timely analytical research on the performance of the property and casualty insurance sectors is needed. If such research is not generated by the investment community, scholars, public affairs analysts and empirically minded legal scholars, then more reliance will have to be placed on industry associations. Inevitably, however, such research will always be tainted as somewhat self-serving. Some independent analysis is therefore required. The concerns of the governments responsible for insurance matters should extend to include more research. In the opinion of the Task Force, an analytical review of the insurance industry by Parliamentary and Legislative committees should be at least an annual affair.

One of the central issues arising out of the stability analysis is whether public authorities should have some regulatory power to promote more efficient and timely adjustments by the industry of the price and availability of insurance services. Presumably, such activity could be carried on by a branch of a financial services ministry or agency that is separate from the solvency control branch. However, even if a government agency had the information and analytical capability to attempt to steer markets to faster and more appropriate adjustment, one must first determine whether it should be permitted to do so. Who will be responsible if governments push price increases earlier and in larger degree than the competitive market is capable of handling? What will be the liability of the government if a number of firms get into trouble by following government advice or direction? These issues are considered in detail in Part D of the Report.

Affordability

An analysis of average family expenditures in Canada indicates that personal insurance costs are minor budgetary items (see Table 2). During 1982, personal insurance payments made to the property-casualty industry (tenants' insurance premiums, homeowners' insurance premiums, and vehicle insurance premiums) accounted for only 2.0% of the family expenditure budget. Other insurance-related expenditures include: health insurance premiums (private and public), 0.7%; life insurance premiums (including group insurance premiums), 0.8%; unemployment insurance, 0.9%; and retirement income maintenance, 2.5%.

Although a relatively minor budgetary expenditure, sharp increases in personal insurance premiums have stretched those on tight budgets and created uncertainties in the budgeting process. A similar conclusion can be drawn for municipalities and hospitals faced with large premium increases. The exception in these situations is the unavailability of coverage in certain cases and the consequent resorting to reciprocal insurance arrangements.

TABLE 2
AVERAGE EXPENDITURE IN CANADA, 1978 AND 1982
ALL FAMILIES AND UNATTACHED INDIVIDUALS

	Dollars		Percentage of Total Expenditure	
	1978	1982	1978	1982
Food	3,188.5	4,131.1	16.8	15.3
Shelter	3,060.7	4,742.0	16.1	17.5
Tenants' insurance premiums	**3.0**	**22.0**	**0.0**	**0.1**
Premiums for insurance on home	**65.4**	**146.2**	**0.3**	**0.5**
Household Operation	782.0	1,177.1	4.1	4.3
Household Furnishings and Equipment	868.4	972.0	4.6	3.6
Clothing	1,298.7	1,650.6	6.8	6.1
Personal Care	312.6	490.8	1.6	1.8
Medical and Health Care	368.1	522.2	1.9	1.9
Health insurance premiums	**142.4**	**190.0**	**0.7**	**0.7**
Tobacco and Alcoholic Beverages	613.6	892.2	3.2	3.3
Transportation	2,425.6	3,270.6	12.7	12.1
Vehicle insurance premiums	**241.8**	**382.3**	**1.3**	**1.4**
Recreation	947.7	1,261.4	5.0	4.7
Reading	108.1	157.9	0.6	0.6
Education	121.3	188.3	0.6	0.7
Miscellaneous	461.9	796.5	2.4	2.9
Total Current Consumption	**14,557.2**	**20,252.8**	**76.5**	**74.8**
Personal Taxes, Security and Gifts	4,476.6	6,809.4	23.5	25.2
Life insurance premiums including group	**175.5**	**220.0**	**0.9**	**0.8**
Annuity contracts	**27.5**	**38.1**	**0.1**	**0.1**
Unemployment insurance payments	**163.8**	**254.0**	**0.9**	**0.9**
Retirement and Pension Fund payments	**425.4**	**649.7**	**2.2**	**2.4**
TOTAL EXPENDITURE	**19,033.7**	**27,062.3**	**100.0**	**100.0**

Note: *Details may not add due to rounding.*
Source: Statistics Canada, *Family Expenditure in Canada*, Cat. No. 62-551 and 62-555, Occasional Percentage Calculations by the Economics Practice, Coopers & Lybrand.

Macro-Analysis: Conclusion

Although the overall profitability of the property-casualty insurers is more unstable from year to year than that of other financial services, partly as a consequence of the insurance cycle, the overall financial record is fairly strong. The average rate of return on equity during the period 1979-1984 for the industry as a whole is 9.3%. The property-casualty industry in Canada is one of the best-capitalized industries in the economy. Over the past 15 years, equity held in the industry has grown at an annual compound rate of 11.2%, from $958 million in 1970 to $5.7 billion during the third quarter of 1985. (See Appendix 7.) An examination of the composition of the equity reveals that retained earnings and head office accounts (a measure of the initial seed capital and retained earnings attributable to Canadian branches of foreign companies) are the major items.

In view of the instability of profits, one might have expected that the average rate of return on equity in the property-casualty insurance industry would have to be slightly higher than the Canadian average, to compensate for the risk and variability. However, the average appears to be slightly below some obvious alternatives such as banks and trust and loan companies. The high retention rate of profit in the industry and the strong growth in equity point to the underlying strength of the industry. There are no signs of major capital withdrawals, so that can be ruled out as an element in the insurance crisis. Indeed, from an overall point of view, the capacity of the industry to supply insurance is far from being strained. Why then are insurance services sometimes unavailable or prohibitively expensive?

The macro-analysis highlights two contributory reasons, the first being the long-term instability created by the over-reliance on investment income. The second is the problem of slow industry response to the ongoing cyclical and external changes that impact on the industry. A more complete answer, however, is provided from a micro-analysis perspective.

Insurance Cycle: Micro-View

The nature of the current problems begins to emerge when a more micro approach is taken, wherein the trends and cycles for particular lines of insurance are examined along with the problems of particular groups of insurers facing particular kinds of risks.

General liability insurance accounts for about 5% of the premiums of the property and casualty insurance industry, but for about "half" the problems. It is the locus of the worst deterioration of loss ratios. Liability lines are where the sharpest increases in claims reserves have occurred in recent years.

In general liability insurance, whole classes of insureds have faced premium increases of 50%, 100% and occasionally 500% along with coincident reductions of coverage. However, for automobile insurance, which accounts for more than 45% of the total premium dollars, and for property insurance, which makes up about 40%, no massive *general* problems have arisen in the cycle.

Table 3 has been supplied by the Insurance Bureau of Canada. For property insurance, loss ratios in 1985 have increased a little from the 1983 and 1984 levels, but they are not above the average for the last six years. The loss ratios for automobiles have deteriorated somewhat more lately and are slightly above the six-year average. The losses are not acceptable from a long-term point of view, but massive increases in premium rates are not required to bring about an acceptable balance. Thus, for at least 85% of insurance services to the public, no major price or availability problem arises. The level of and deterioration in loss ratios in liability insurance are startling by comparison.

These views of the issues are sharpened by Charts 3 and 4. Chart 3 shows the recent trends in insurance experience for private passenger third-party liability. This is the coverage by which a person's insurer pays for bodily injury and property damage to other people arising from automobile accidents. Average premiums for third-party liability have lagged increases in the Consumer Price Index (CPI), the Insurance Advisory Organization (IAO) recommended rate, and claims losses. The IAO data also shows that after adjustment for inflation, the average premium for third-party liability experienced a cumulative decline of 11.2% over the six years.

In the paper prepared by Coopers & Lybrand, a general liability rate index has been set out. That experience suggests that earned premiums are significantly inadequate to cover losses and have lagged increases in the CPI by a substantial margin. After adjustment for inflation, earned premiums have experienced a cumulative decline by 1984 of 28.9% over the six-year period, reflecting competitive pricing practices.

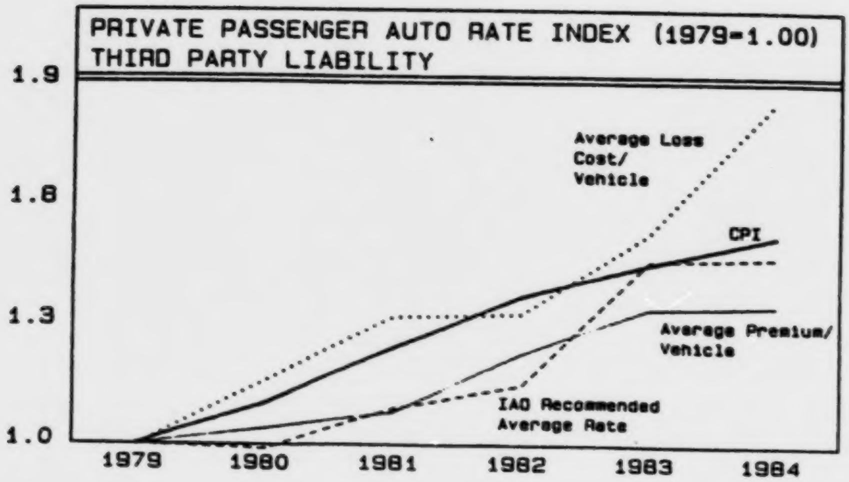
TABLE 3
EARNED PREMIUM, INCURRED LOSSES* AND LOSS RATIO BY MAJOR CLASS

		PROPERTY				AUTOMOBILE				LIABILITY			
		Earned Premium	Incurred Losses	Loss Ratio	Year To Date	Earned Premium	Incurred Losses	Loss Ratio	Year To Date	Earned Premium	Incurred Losses	Loss Ratio	Year To Date
1980	1	434,586	320,140	73.7	73.7	567,424	469,940	82.8	82.8	75,251	45,567	60.6	60.6
	2	451,319	329,412	73.0	73.3	581,677	400,559	68.9	75.8	80,891	42,633	52.7	56.5
	3	473,269	330,672	69.9	72.1	620,161	510,289	82.3	78.0	76,067	51,442	67.6	60.1
	4	572,481	435,598	76.1	73.3	632,363	596,244	94.3	82.3	83,931	44,185	52.6	58.1
1981	1	483,422	386,500	80.0	80.0	623,476	583,748	93.6	93.6	82,675	49,490	59.9	59.9
	2	505,441	334,397	66.2	72.9	657,622	503,658	76.6	84.9	86,881	52,104	60.0	59.9
	3	541,086	403,245	74.5	73.5	697,594	597,215	85.6	85.1	85,444	49,764	58.2	59.4
	4	605,221	476,848	78.8	75.0	726,649	697,139	95.9	88.0	98,708	102,339	103.7	71.7
1982	1	561,503	465,521	82.9	82.9	749,301	663,489	88.5	88.5	94,494	68,794	72.8	72.8
	2	595,584	397,750	66.8	74.6	792,078	543,280	68.6	78.3	102,513	90,431	88.2	80.8
	3	617,832	381,238	61.7	70.1	837,958	585,099	69.8	75.3	106,219	84,893	79.9	80.5
	4	656,778	402,386	61.3	67.7	895,821	689,727	77.0	75.8	117,659	119,823	101.8	86.5
1983	1	621,687	381,229	61.3	61.3	860,396	572,892	66.6	66.6	110,960	90,191	81.3	81.3
	2	673,370	375,811	55.8	58.5	878,266	571,240	65.0	65.8	119,186	110,565	92.8	87.2
	3	682,974	425,088	62.2	59.8	902,544	647,878	71.8	67.8	116,843	102,120	87.4	87.3
	4	722,123	460,611	59.6	59.7	960,145	864,494	90.0	73.8	113,611	159,650	140.5	100.4
1984	1	684,648	424,989	62.1	62.1	901,099	711,290	78.0	78.9	116,288	115,287	99.1	99.1
	2	687,288	431,509	62.8	62.4	915,580	668,530	73.0	76.0	112,932	115,339	102.1	100.6
	3	708,726	448,316	63.3	62.7	954,637	780,537	81.8	77.9	116,031	117,191	101.0	100.7
	4	760,839	502,950	66.1	63.6	946,882	949,573	100.3	83.6	142,034	178,419	125.6	108.0
1985	1	718,333	502,999	70.0	70.0	921,932	839,328	91.0	91.0	120,235	118,820	98.8	98.8
	2	739,497	538,518	72.8	71.4	957,689	806,910	84.2	87.6	132,505	123,934	93.5	96.0
	3	763,232	504,089	66.0	69.6	1,014,234	875,490	86.3	87.1	140,275	130,971	93.4	95.1
	4	800,257	506,402	63.3	67.9	1,065,250	1,181,078	110.9	93.5	221,108	228,569	103.4	98.1

		PROPERTY – PERSONAL				PROPERTY – COMMERCIAL			
		Earned Premium	Incurred Losses	Loss Ratio	Year To Date	Earned Premium	Incurred Losses	Loss Ratio	Year To Date
1984	1	355,410	212,162	59.7	59.7	329,238	212,827	64.6	64.6
	2	378,961	234,401	61.9	60.8	308,327	197,108	63.9	64.3
	3	386,545	240,042	62.1	61.2	322,181	208,274	64.6	64.4
	4	413,109	233,713	56.6	60.0	347,730	269,237	77.4	67.9
1985	1	411,489	267,602	65.0	65.0	306,844	235,397	76.7	76.7
	2	418,303	295,364	70.6	67.8	321,194	243,154	75.7	76.2
	3	433,737	283,646	65.4	67.0	329,495	220,443	66.9	73.0
	4	439,594	272,083	61.9	65.7	360,663	234,319	65.0	70.8

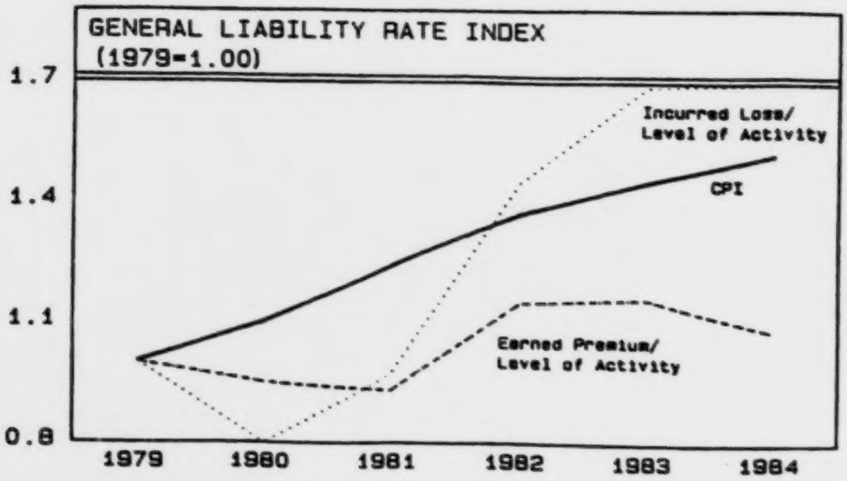
*Includes all adjustment expense.

CHART 3



Source: Insurers' Advisory Organization of Canada and Statistics Canada, *Consumer Prices and Price Indexes*, Cat. No. 62-010.

CHART 4



Source: Insurers' Advisory Organization of Canada and Statistics Canada, *Consumer Prices and Price Indexes*, Cat. No. 62-010.

IV CONCLUSION

The analysis in Part A has been complicated by the tangled interaction of the various cyclical and transitory random economic forces together with the fundamental structural, technological, social and legal changes that all affect the current insurance industry. In unravelling this skein, the Task Force has reached the following conclusions:

First, the heavy concentration of problems in the general liability insurance lines is an unusual feature of this cycle. It has been argued here, and will be argued more fully in Part B, that the general liability area has been the most severely hit by the fundamental structural changes in technology, in societal values and in the practice of civil law that we are currently experiencing. It is therefore on this area of insurance that the Task Force has focused much of its attention.

Second, a number of longer-term trends have significantly influenced various aspects of risk and insurance and compensation. Thus, although there is no general crisis of price or availability of personal automobile insurance in Ontario, there are clear indications of a trend of increase in the real cost of claims for bodily injury, together with indications of a trend towards a more litigious approach to such claims. These trends have little to do with the insurance cycle, but they have become more visible as the trough of the shift to a hard market has approached.

Third, there are always more difficult and less profitable risks to insure within any given pool, even in sectors such as property insurance or personal automobile insurance. When a hard market appears, the retrenchment nearly always falls more heavily on the more difficult risks within any pool. Many problem areas therefore appear as a by-product of the cycle. Easing those problems will not reverse the cycle. However, neither will a reversal of the cycle correct all the problem areas.

Fourth, even though some of the fundamental structural changes are neither a cause nor an effect of the insurance cycle, the mood of retrenchment in a "hard" market situation inhibits the bold new long-term commitments that may be essential to resolve those fundamental problems.

The analytical focus of the Task Force was based on four sets of questions designed to provide a greater insight into the causes and effects of and possible solutions to the current insurance crisis. The analysis in Part A permits us now to answer these questions:

1. While many industries are characterized by cyclical changes in supply and capacity, why is the instability in the general insurance industry so high?

The explanation for the unusual degree of instability in the insurance industry is twofold. In part, it is due to the highly fragmented nature of the industry. Entry and exit have been all too easy, and the supply of insurance has been volatile and elastic. In part, the instability is due to the unique contingent quality of the insurance product itself. More specifically, the increasing uncertainty surrounding the nature and extent of the liability risks to be insured is making it virtually impossible for insurers to price many products with a reasonable degree of predictability. When the situation reaches the point that insurers feel that they are forced to assume the risk rather than simply pool it, the understandable response is to withdraw or substantially reduce capacity.

Given that markets with high degrees of instability are prima facie poorly functioning, changes are clearly required in the insurance industry. The Task Force has considered two basic areas of change.

The first is designed to reduce the excessive structural fragmentation in the industry. This could be accomplished indirectly through increases in the barriers to entry, such as initial capital requirements. This and other suggestions are developed in Part D.

The second proposed change is designed to reduce the uncertainty surrounding the particularly problematic general liability risks, especially as they relate to personal injury compensation. This is discussed in Parts B and C.

2. If the property and casualty insurance industry is as effectively competitive as most scholars and business persons believe, what explains the observation that, in the current hard market, the prices of some kinds of insurance services appear to have increased much more than the record of average cost increases?

This question focuses on the apparently excessive increases in premiums in relation to claims paid out. More specifically, it addresses the question posed by so many organizations to the Task Force about why insurance premiums have increased in one year by over 100% (300%, 500%) when the record of claims has involved small payouts compared with the premiums. The explanation is again related to the extreme difficulty in evaluating so many liability risks, and in anticipating judicial developments in respect of both the parameters of liability and the quantum of damages. It does seem clear, however, that there is an element of overreaction to this situation on the part of the industry. This can certainly be moderated somewhat by an improvement in data bases and by enhancing the availability of accurate underwriting information and of the precise record of experience for particular risks. In addition, the insurance industry must also simply improve its underwriting skills and become more adept in interpreting and analyzing the available information.

3. How can the assertions that 1984 and 1985 were years of large loss ratios for property and casualty insurance companies be reconciled with the evidence of increased prices of listed shares of such companies and with reports of high prices of acquisitions of other companies?

The explanation for this question is fairly clear. It appears that potential buyers of insurance company stocks or of insurance companies saw in 1985 and early 1986 that premium increase decisions were made that, they believed, would lead to rapid increases in premium incomes during the next two or three years. Substantial investment was predicated on the expectation that those increases would exceed the increases in claims incurred. The combination of that expectation and the general bull market in listed stocks have interacted to produce large increases in the prices of insurance stocks. The paradox may be that the combination of increased premium rates and reduced availability of insurance may make the insurance industry much more profitable, precisely at the time when it is coping with fundamental social transformations in the demand for insurance less successfully.

It remains to be seen, however, whether these investors have sufficiently appreciated the unique character of the current cycle.

4. If, as appears to be the case, fundamental structural changes affecting insurance have been underway for many years, why have they only been recognized now?

This question relates to the failure of the industry to recognize and to adapt sufficiently to the fundamental underlying structural changes that have so profoundly altered the current risk environment. The explanation lies in a combination of a number of factors. In part, the failure to respond is due to the paucity of comprehensive data analysis of both the current risk environment and the benefit of structural change.

In addition, it appears that the current distribution system, involving insurers, brokers and agents, has prevented adequate linkage between the insureds and insurers. The industry has also been slow to adopt technological changes that would enhance this link. Proposals to implement changes in the distribution system are set out in Parts C and D, and should assist in improving the responsiveness of the system.

Above all, however, the failure to respond is due to the inherent inertia of the current insurance system that inevitably precludes consideration of the sort of comprehensive systemic reforms that appear necessary to resolve the current insurance crisis. It is anticipated that the recommendations contained in this report will assist in dispelling this inertia. Moreover, as new financial conglomerates expand into the general insurance industry with more innovative products and services, one can expect to see an acceleration in the pace of change.

NOTES — PART A

[1] Mathewson and Winter, "The Market for Property and Casualty Insurance in Ontario" (April 15, 1986), pp. 4-5.
[2] Mathewson and Winter, Part III (4).

[3] Mathewson and Winter, p. 10.
[4] Trebilcock, "The Insurance-Deterrence Dilemma of Modern Tort Law: Trends in North American Tort Law and their Implications for the Current Liability Crisis" (April 21, 1986).

PART B

THE CRISIS IN LIABILITY INSURANCE

PART B

THE CRISIS IN LIABILITY INSURANCE

There is no doubt that the current insurance crunch is dominated by a crisis in liability insurance. As noted above, the causes of this crisis are difficult to discern but relate primarily to the extreme uncertainty associated with "long-tail" risks. The insurer's exposure may extend for many years beyond the time when the insured occurrence took place, and systemic socio-legal and economic changes are constantly shifting the parameters of liability and quantum of damage. This uncertainty has made it impossible for insurers to price the various types of risks and has led directly to the severe problems in availability, adequacy and affordability of liability insurance coverage.

This Part will first address the nature and extent of the liability crisis. Next, the variety of responses to the crisis that have emerged on the part of both insurers and insureds will be discussed. Proposals for reforms will then be put forward that are designed to enhance capacity in the more intractable areas where the availability, affordability and adequacy of liability insurance is particularly problematic.

A third section will then review and assess the case for tort reforms. Finally, the concluding section will address the need for a fundamentally different approach to accident compensation.

I THE NATURE AND EXTENT OF THE LIABILITY INSURANCE CRISIS

Background

Liability insurance is the particular type of insurance that has been most affected by the "hard" market. While there are different liability insurance products, the problems are common to each, whether third-party liability coverage under a commercial vehicle insurance policy or various coverages under a commercial general liability insurance policy. Product manufacturers, municipalities, tavern owners, hotels, hospitals, volunteer groups, contractors, truckers, bus operators and newspapers are all exposed to the risk of claims being brought against them for injuries or damages. The purpose of liability insurance is to protect the insured against many of these risks.

General liability insurance represents approximately 5% of the premiums written by the general industry in Canada, but has generated a disproportionate portion of underwriting losses (some 8.8%). It is all too clear that liability insurance problems are the critical, dominant element of the current crisis and must therefore be addressed on a priority basis. The problems are not just transitory; many entail enduring structural changes.

It is clear to the Task Force that the origin of the crisis lies in the extreme uncertainty that is now associated with underwriting certain liability risks. As insurers often point out, their role is to spread risks, *not* assume them — a role that cannot be fulfilled without at least a minimum degree of predictability. This unacceptable degree of uncertainty is generated by a number of structural sources, which have impacted most strongly on the United States but have also affected Canada:

(1) The increasing incidence of product liability lawsuits as more complex and potentially hazardous products enter the market.

(2) The unknown and long-tail nature of many existing environmental risks and hazards generated by a more complex, technologically advanced society.

(3) The seemingly open-ended and unpredictable court awards and settlements in the United States, particularly for product and professional liability suits — a trend that insurers expect inevitably to take root in Canada. This applies both to the extent of coverage under an insurance policy as the courts expand the scope of liability to permit compensation effectively on a no-fault basis, and to the quantum of damages.

(4) The increasing transactions costs associated with the return of the premium dollar to the consumer in the form of claims paid. This applies especially to legal defence costs in connection with the escalating numbers of court awards and settlements referred to in (3).

(5) The increased propensity of consumers to litigate and the trend toward the so-called "risk-free" society.

(6) The failure of risk management and risk control and reduction techniques to keep pace with advancing technologies, more complex products and heightened consumer consciousness and expectations.

There are, of course, also cyclical features to the liability insurance crisis. To understand these, a brief sketch of the structure of the relevant segment of the property and casualty insurance industry is required, together with a description of its performance in response to recent internal and external pressures.

Only a few of the many insurers in Ontario have been in a position to handle specialty classes of insureds such as municipalities, professionals, hospitals, buses and long-haul truckers. These insurers tend to be the smaller insurers and, owing to the relatively small premium volume in specialty liability lines, are required to spread the risk throughout the worldwide reinsurance market.

But during the heady period of rising interest rates in the early 1980s, many of these insurers became dangerously over-reliant on this reinsurance, and engaged in destructive cash flow underwriting, using investment gains to offset underwriting losses, in order to maximize market share. The adverse consequences of this were not immediately recognized since insureds of all types appeared to benefit from reductions in insurance premiums to unusually low levels.

But by 1982, interest rates began to fall and investment income to decline. At the same time claims were rising in both frequency and size, and liability settlements in the United States in particular were increasing dramatically far beyond those anticipated when the prices for earlier years had been set. In Canada, the loss ratio on liability insurance was over 100% in 1984 and almost 100% in 1985.

Into this rather unstable environment were injected a series of unanticipated international catastrophes such as Bhopal, earthquakes and the hijack of the *Achille Lauro*. In addition, huge United States court awards and product liability exposure in the asbestosis cases increased claims exponentially and cut deeply into reserves. Other major product liability cases also emerged. These developments accelerated in 1984-1985, culminating in the sudden contraction of reinsurance with the expiry of reinsurance treaties on December 31, 1985 — something that had an immediate and negative impact in almost all areas, with the possible exception of personal property insurance coverage, which has only a small liability component. It has been estimated that overall reinsurance supply dropped by some 50% to 60%.

With the collapse and withdrawal of many offshore reinsurers and the insolvencies of no fewer than five active domestic insurers, the liability market has now shrunk dramatically. Moreover, specialty lines are always the first to feel the effect of the cycle. Most reinsurance treaties are renewed at year end and coincide with the policy renewal time for many organizations. At the end of the calendar year 1985, the restrictions and high cost of reinsurance drove the cost of insurance up dramatically for those who were able to find an insurer willing to provide a market. Insurers took steps to reverse the excessive price reductions in liability insurance that had occurred during the "soft" market, with the result that, for example, a premium increase of 500% was required to offset a prior premium reduction of 80%. The correction process is now underway and is probably a first step in bringing stability back to the market.

To acknowledge that premiums may have been unrealistically low in recent years is not in any way meant to condone the dramatic swings in premium levels, nor to justify the means by which the cyclical correction is being undertaken. As noted earlier, from the perspective of the insured, any market that gives rise to such swings is unacceptable, and the many cases of negligible notice of non-renewal of coverage or huge increases in premiums have caused widespread public outrage. While the cyclical features of this crisis may eventually work themselves out and premium levels may stabilize, action is certainly required to prevent any repetition of the more egregious developments. Certain recommendations will be put forward in this regard in Part D dealing with the role of government.

Having set out the fundamental nature of the structural and cyclical sources of the current liability insurance crisis, it is useful to turn to an examination of the immediate problems of availability, adequacy and affordability, and their impact on a wide variety of insureds.

Problems of Cost, Adequacy and Availability: Impact on Specific Insureds

In general, insureds are concerned with increased costs, higher deductibles, lower limits, cancellations, restrictive coverage and overall availability of liability insurance. For their part, insurers want a price that covers their anticipated claims and costs, more realistic deductibles and limits, and greater certainty in assessing risk. Higher claims and settlements both in and out of court, capacity shortages in the primary and reinsurance markets, price competition in the past, lower investment returns, the risk-free expectations of society, and liberal interpretation of policy coverage by the courts have all contributed to the present situation.

At the present time, it appears that most entities can obtain liability insurance coverage, although this may require unusual effort. In many cases, the problem is not availability but acceptance of the cost. Insureds that paid a few thousand dollars for a million dollars of coverage in the past when competition for market share led to unrealistically low premiums did not, or could not, easily adjust overnight to much higher premiums. For example, an increase in the annual premium from $3,000 to $18,000 is clearly difficult to accept, even though the reasons behind the increase may turn out to be entirely justifiable.

Availability of liability insurance is, however, a definite problem for specific entities. These include many small and medium-sized businesses and many non-profit organizations. Other entities have obtained liability insurance for most risks but have been left facing significant exposures with respect to sub-risks such as pollution and environmental damage. These problems have been partially alleviated in the short term by pools set up with the encouragement of the Province of Ontario and the co-operation of the insurance industry. For example, an association of insurance companies was formed in Ontario to provide liability insurance to small businesses and non-profit organizations that could not otherwise obtain coverage. An earlier pool was formed to provide coverage for pollution risks and risks arising under the "Spills Bill". Special steps have also been taken to extend the Facility Association activities to provide insurance to trucking companies caught by the difficulties of the United Canada Insurance Company and to provide the additional coverage required by those travelling to the United States.

These steps have undoubtedly been somewhat helpful in the shorter term and demonstrate that the parties involved can work together in resolving problems. In the longer term, however, more will have to be done since it is unlikely that the soft markets of the past will return in the near future with respect to liability insurance. More importantly, as already noted, the liability insurance crisis reflects fundamental structural, as opposed to merely cyclical, changes. These require special attention.

It would be useful at this point to set out a somewhat more detailed description of the impact of the crisis on specific insureds who, in the Task Force's view, will require special attention from the government in overcoming the cost and capacity problems. This will then permit a more meaningful assessment of the responses to the crisis and proposals for change set out in the next section.

Manufacturers

Manufacturers in Ontario have faced significant increases in premiums for liability insurance. Many smaller companies were unable to obtain liability insurance before the Ontario Liability Insurers' pool was formed. What liability insurance has been obtained has generally contained higher deductibles and less overall coverage.

A special Canadian Manufacturers' Association survey of members indicated that nearly half of their respondents experienced a doubling of their liability insurance premiums for 1986 and a reduction in coverage. In addition, 30% of the respondents stated that their insurance coverage is inadequate to cover their operations. Finally, substantial premium increases of some 600% to 800% are not uncommon. Particular problems relate to product liability insurance on exports to the United States and to coverage for environmental impairment and "sudden and accidental" pollution.

Exporters to the United States

Product liability insurance for exports to the United States can be very costly and coverage can be very restrictive. Availability at any price is a major concern. Moreover, many exporters must provide evidence of liability insurance before goods are accepted in the United States. It is interesting to note that similar problems are encountered by exporters from such places as the United Kingdom, Japan and Europe.

Given that more than half of Ontario's gross provincial product is derived from exports of goods and services to the United States, mainly by small and medium-sized businesses, it is clearly of critical importance to ensure access to adequate and affordable insurance in order not to restrain exporting activity. As noted later, this is likely to require careful assistance from governments, with a view to avoiding any semblance of subsidization that would invite countervailing action in the United States.

Day Care Centres and Similar Facilities

The problems in respect of these insureds appear to have originated in the United States with allegations of injuries from poor-quality care and of child and sexual abuse. Insurers now consider these facilities to be vulnerable, and the market has retracted notwithstanding the fact that Canada has no experience of liability claims for child abuse in day care centres. Policies may now specifically exclude claims for damages for such abuses.

In Ontario, the *Day Nurseries Act* requires each day nursery or private-home day care agency to maintain in force a comprehensive general liability policy. Many day care centres have been forced to resort to the Ontario Liability Insurance pool in order to continue in business.

Truckers

Problems in the trucking industry were widely publicized during the United Canada crisis. Truckers have traditionally been underwritten by a few specialist companies (one of which was United Canada), and few other underwriters had the experience or interest to step in to fill the gap. The insurance industry responded quickly by opening up the Facility Association to commercial vehicles (including trucking into the United States) and by providing higher limits ($5 million U.S.) where required. Despite this step, truckers are finding that the current insurance market is very tough and expensive and that there is little adequate coverage available. Particular problems are associated with liability insurance for environmental impairment and "sudden and accidental" pollution.

Bus and Transit Operators

Bus and transit operators were also hit hard by the tight market. Very substantial premium increases, in some cases ranging from 1,000% to 2,000%, and reduced coverage were commonplace. School bus operators in particular have little ability to absorb the additional cost, and the ultimate burden will inevitably fall on school boards and municipalities.

Municipalities and School Boards

Liability insurance problems affecting municipalities and school boards are particularly severe. Threatened cancellations of recreational activities, stories of municipalities and school boards going "bare" have been common. Given the implications to the Province of Ontario, it is assumed that the government has provided, and will continue to provide, direction and assistance to municipalities and school boards. As discussed later in this Part, reciprocal and inter-insurance exchange arrangements may offer a longer-term solution. In addition, the interim report of the Municipal Insurance Advisory Committee provides a valuable analysis of the problems and possible directions for change. The recommendations are summarized in Appendix 18 under "Municipalities". The final report is expected in September.

Professionals

Professionals such as architects, engineers, doctors, nurses and chartered accountants are also encountering severe problems in obtaining liability insurance or are facing premium hikes, some as much as several hundred per cent. The particular difficulties of professionals and the proposals for reform are succinctly set out in a special paper prepared for the Task Force that is attached herewith as Appendix 10.

Directors and Officers

Adequate liability insurance for directors and officers (D&O) is virtually unavailable. It seems that there are currently only two main sources of D&O insurance left in North America: American International Group in New York and Encon Insurance Managers Inc. in Ottawa. One firm with no claims history had its liability limit cut from $75 million to $15 million over two years and its premiums raised from $60,000 to $650,000. In March, it was reported that two directors of a petroleum company in Calgary who were based in the United States resigned, citing a lack of coverage. For $5,000 to $6,000 in directors' fees, continuation of service was simply not worth the risk.

Volunteer and Charitable Organizations, Sports and Recreation Groups

Volunteer and charitable organizations such as the St. John Ambulance and the Red Cross have faced dramatic premium increases or indeed instances of total non-availability of liability insurance for their volunteers. Eventually they found limited coverage for their volunteers but at premium levels several hundred per cent higher than for the preceding year.

Liability insurance costs for sports and recreational groups have risen from 150% to 900% for both provincial and community-based organizations. A survey conducted by the Ontario Sports Medicine and Safety Advisory Board determined that more than 55% of the municipalities surveyed no longer provide liability coverage for community groups using public facilities. Reports of activities being terminated by reason of lack of insurance have been common.

Insurers point to high court awards in the United States and to the high legal cost of defending even frivolous claims, while the insureds argue that the increase in premium rates and the reduction of coverage have no apparent relationship to the history of the claims against the insured. For example, the number of claims filed against provincial sport and recreation organizations over the last three years appears to be less than 10, with an average settlement of less than $1,000. Unfortunately, however, two recent claims have initially been listed at $3.9 million and $1 million respectively — something that insurers obviously consider in establishing the new premium levels, even if the claims are not ultimately successful.

Hospitals

Hospitals face a 362% increase in the basic cost of liability insurance in 1985-1986. The percentage of the total provincial hospital operating budget spent on liability insurance premiums increased from 0.093% or $3.5 million in 1983-1984 to an estimated 0.947% or $41 million in 1985-1986. Increasing litigation is obviously a significant factor in the problems of cost and availability. Statistics compiled in respect of doctors are useful in this area. The number of doctors involved in litigation in Canada has increased from 516 in 1982 to 1,266 in 1984 and to over 1,500 in 1985, and in Canada the total amount paid out by the Canadian Medical Protective Association, which insures over 85% of doctors, rose from $5.96 million in 1982 to $13.78 million in 1984. Most of these malpractice suits involve both the physician or surgeon and the hospital in which the medical act occurred (and often involve complex issues of the allocation of responsibility between the hospital and the doctors).

The availability of liability insurance for hospitals is now severely limited, and there is no longer a truly competitive market. Only two major insurers remain: Scottish & York, the insurers of the Ontario Hospital Association's Comprehensive Insurance Program (CIP); and the Guarantee Company of North America, through its brokers, Frank Cowan Company of Princeton, Ontario. As of March 1986, 130 public hospitals out of a total of 350 hospitals and allied health institutions in Ontario (60%) obtained their insurance, including liability insurance, through the CIP. In the current volatile market, the continued provision of coverage is not certain, and the shift to claims-made policies from the occurrences form is likely to take place.

Hospitality and Tourism

All submissions received from associations in the hospitality and tourism industry stressed a problem with cancellations and non-renewals as well as with significant increases in premiums and deductibles. In particular, it was requested that the *Insurance Act* (Ontario) be amended to require 90 days' written notice to the insured if the insurer intends to:

- cancel a property or casualty insurance policy;
- not renew a policy; or
- raise the premium or increase the deductible.

It was further requested that a notice to raise premiums or deductibles state the amount of the increase.

Taverns

Increased public concern over drinking and driving in the United States as well as in Canada has shifted greater responsibility to the tavern owners and created higher exposure. The increasing frequency and severity of judgments against establishments serving alcoholic beverages have resulted in substantial premium increases, higher deductibles and availability problems. While the situation in Canada is not yet as severe as in the United States, the same trend toward expanding the scope of liability for third-party injury imposed on tavern owners is very clear.

II RESPONSES TO THE CRISIS AND PROPOSALS FOR REFORM

Responses by Insurers

The primary way in which the industry has addressed the liability insurance crisis is through reductions in coverage, increased premiums, and in some cases the total withdrawal from underwriting in certain areas. This will be discussed with specific reference to claims-made policies, environmental impairment and pollution exclusions, and the treatment of legal defence costs within policy limits.

Claims-Made Policies

Perhaps the most important change in the way liability risks are insured is the development of a new commercial policy form — the claims-made policy. Comprehensive general liability insurance, including product liability coverage, has traditionally been written on an occurrence basis. The fundamental difference between the occurrence form and the claims-made form is the event that triggers policy coverage. In the occurrence form, an occurrence in the policy period resulting in damages covered by the policy triggers the policy coverage, whether or not a claim is filed during the policy period. The key date is the date of the occurrence rather than the date of making the claim. In the pure claims-made form, the key date is the date that the claim is first made. If the claim is made in the policy period, coverage is triggered.

From the viewpoint of the insured, the occurrence form is generally preferable, since the liability for presently unknown occurrences causing injury or damage will be subject to the policy in effect at that time, even if not discovered for many years in the future. The potential for a gap in insurance coverage is therefore minimal, assuming an insurance policy in the occurrence form is in force at all times. One potential problem, of course, is the possibility that the policy limits in effect at the time of the occurrence may prove to be insufficient many years later when the claim is ultimately settled.

The major impetus for the change to the claims-made form was the liability for illnesses with a long latency period or long discovery period and originating from exposure to toxins, drugs or other products, notably diethylstilbestrol (DES) taken during pregnancy, asbestos, etc. It took many years for the deadly effects of asbestosis to manifest themselves, and it took many years before the bodily injury arising in children of women who had taken DES was linked to DES. To provide an extreme example, exposure to asbestos dust in shipyards in 1944 has been judged to be the occurrence that appeared as cancer in the early 1970s and that then gave rise to claims against a company and the insurance contract that was operative in 1944.

According to insurers, the occurrence form for the CGL policy places a significant burden on the insurer to price the policy today without knowing the circumstances that will apply when the policy is triggered in the future. What product-induced diseases will surface many years from now, especially since major scientific and technological advances are leading to the development of many new complex products and processes that may have significant health-related repercussions in the future? How will the the courts interpret the policy at that time? The courts, particularly in the United States, are continually redefining and expanding the meaning of "occurrence", with the result that insurers are exposed to losses never contemplated at the time the premium was set. For example, with respect of the asbestosis claims in the United States, "bodily injury" has been interpreted to mean any part of the single injurious process that asbestos-related diseases entail. Hence there is more than one trigger and more than one policy applying to the same claim, thereby permitting the policyholder to select at will any of the insurers involved over the years to defend its claims and compensate for damages.

The insurance industry asserts that one of the primary purposes of the claims-made form is to ensure that only one policy and one limit apply to a single loss — the policy in effect at the time that the claim is made. In its submission to the Task Force, the Insurance Bureau of Canada has noted that "the introduction of a claims-made version of the CGL allows for precision in determining the coverage period, avoids the stacking of limits and policies that now occurs and avoids costly litigation over policy application". Under a claims-made policy, an insured must inform the insurer as soon as possible after an incident has occurred. But this does not yet trigger the responsibility of the insurer. This occurs later, when a full claim is formally and legally registered. This gives rise to the problem of "tail" coverage. For example, consider an insurance contract for the calendar year 1986: an incident occurs in late November and the insurer is notified by the end of November. But the preparation and registry of a claim may take some months. In what period of time can claims be made against the 1986 insurance contract? On what terms will 1987 insurance contracts be available?

The details of the various forms of claims-made policies that are currently in use or entering into use in both the United States and Canada are set out in a useful paper prepared for the Task Force on Insurance by the consulting firm of Woods, Gordon. The Task Force expects the paper to be of interest to a wide range of insurers and insureds. It would be useful at this point to highlight the problems arising in respect of the claims-made policy, and the ways in which these may be addressed.

To begin with, the Task Force acknowledges that in many ways the public must accept the need to change to the claims-made policy if insurers are to continue to write liability insurance and survive over the longer term. But many legitimate concerns have been raised with respect to the new form that must be addressed by both the insurance industry and the regulators.

The two major problems with the claims-made form can be summarized as follows:

(1) possible absence of insurance coverage due to gaps in time, restrictive coverage or inadequate aggregate limits; and

(2) pricing and obtaining "tail" coverage.

These two problems arise due to certain provisions in the "standard" claims-made policy form, and, in particular:

- the coverage trigger;
- the retroactive date: for example, if the retroactive date is advanced, a gap in coverage will exist between the date of the last occurrence policy and the new retroactive date;
- the sufficiency of automatic tail coverage: the IBC recommends only a 60-day

minimum period within which an insurer is prevented from cancelling a policy after an incident that might cause a claim is reported, but before the actual claim is registered. (The automatic tail has two parts: the mini-tail to allow late reporting of an incident or claim; and a longer tail to provide coverage — and prevent cancellation — for the anticipated losses from known incidents reported to the insurer.);

- the sufficiency and cost of the supplemental tail coverage that applies to incidents reported to the insurer more than 60 days after the expiration of the policy and claims filed more than five years after the expiration date for incidents reported within 60 days (i.e., those falling outside the automatic tail). Concern has been expressed that the standard premium for the supplemental tail will be 200% and will include the full premium for the policy rather than the appropriate portion of the premium for the coverage to which the endorsement applies (e.g., bodily injury);
- laser endorsements: the IBC standard claims-made policy includes endorsements that restrict coverage rather than expand it, with a view to providing greater flexibility with respect to the definition of insurance needs at a more efficient premium cost. But there is a danger that an uninformed insured will not be aware of the implications of the endorsements and that the insurer will force them on the insured, thereby giving rise to gaps in coverage and the need to purchase tail coverage for a product or incident, or simply "going bare" for that liability.

In addition to the foregoing, concerns of a general nature relate to the fact that the claims-made form is far more complex and requires much greater knowledge on the part of the insured. This is particularly important since, in effect, the insurer is shifting part of the underwriting risk to the insured by requiring the insured to define coverage needs more precisely. Three general concerns can be singled out:

- lack of knowledge on the part of both insureds and brokers, leading to a lack of appropriate coverage and protection;
- greater opportunity for insurers to restrict coverage; and
- blanket use of claims-made forms in all cases even if not warranted by the nature of the risk.

To address these concerns, the Task Force recommends that:

B.1 The industry should take immediate steps to ensure clear and timely explanations of the scope and application of the claims-made policy are provided to insureds directly, and through brokers and agents.

In this connection, it must be noted that the Insurance Bureau of Canada has already organized seminars, information briefings and so forth. But given the severe communications problems between insured and broker and between broker and insurer arising from the current distribution system mentioned above, the Task Force believes that the education effort in this area must be greatly enhanced.

The Task Force also recommends that:

B.2 The Superintendent of Insurance should be accorded wider powers of regulation in respect of the approval of commercial general liability policy forms, with a view to imposing minimum standards and to preventing potential abuse of the claims-made form by insurers.

B.3 The Government of Ontario should undertake a review of all statutes requiring minimum commercial general liability insurance coverage to determine if any additional provisions are required in the case of a claims-made policy form, such as mandatory tail coverage.

This should involve the introduction of "statutory conditions" in the *Insurance Act* to deal specifically with the claims-made policy form. Such conditions should set out, for example, the circumstances in which the retroactive date can be advanced or tail coverage applied. In addition, the Task Force is concerned about the apparent trend to adopt the claims-made form for all commercial risks, and would expect the superintendent to ensure that its use is restricted to the open-ended, long-tail, unpredictable liability risks.

Finally, the Task Force recommends that:

B.4 Specific attention should be given to the claims-made policy form in establishing regulations with respect to minimum notice periods for non-renewals of coverage, mid-term cancellations and changes in coverage. (See Recommendation D-29.)

Environmental Impairment and Pollution Exclusions

Owing to a combination of new legislation reflecting the intensified public concern with environmental risks and hazards, judicial interpretations of policy language, and the inherent uncertainty surrounding an increasing number of such risks and hazards, the availability of insurance coverage for "sudden and accidental" pollution has shrunk considerably, while coverage for environmental impairment and longer-term pollution risks has virtually dried up. Indeed, the claims-made commercial general liability policies of both the Insurance Bureau of Canada and Lloyd's of London specifically exclude pollution coverage.

The new legislation is Part IX of the *Environmental Protection Act*, which was proclaimed in force on November 29, 1985. This imposes strict liability for environmental waste discharges on both owners of substances that pollute and persons in control of substances that pollute (e.g., carriers). The so-called "Spills Bill" requires such owners and controllers to finance the clean-up and restoration costs, as well as satisfy other property damage claims, bodily injury claims and pure economic loss claims.

The insureds most affected by the capacity and availability problems in respect of pollution coverage are the primary producers and distributors, such as oil companies, service stations, chemical producers, manufacturers and distributors, and carriers of potentially hazardous products (such as PCBs). In addition, great concern has been expressed over potential liability exposure by those industries that have voluntarily taken steps to deal with pollution events in an emergency. These include the petroleum industry's land spill co-operatives and the Petroleum Industry Marine Environmental Co-op of Ontario (PIMEC), as well as the Canadian Chemical Producers' Association's Transportation Emergency Assistance Plan (TEAP). (Most road carrier risks are still covered by the standard automobile policy.)

The Ministry of the Environment has also expressed concern over the inability of pesticide operators licensed by the Ministry to obtain the necessary liability insurance mandated under the *Pesticides Act*. Similar difficulties are being encountered by operators of waste management systems and waste disposal sites, including the Ontario Waste Management Corporation in respect of its handling and disposal of hazardous waste.

In response to the crunch, the Government of Ontario, acting initially with the Insurance Bureau of Canada and then with approximately 25 Canadian insurers, was instrumental in creating the "Limited Pollution Liability Insurance Pool", or "Spills Pool", now administered by Insurers' Advisory Organization. Its terms of reference include providing "sudden and accidental" pollution coverage only for those risks with relatively minor pollution exposures that are unable to obtain pollution coverage within the CGL policy. Endorsements are issued for limits up to $1 million. Limits in excess of this amount are recoverable from the Environmental Compensation Corporation established within the Ministry of the Environment pursuant to the "Spills Bill". At present there are seven categories of risks ranging from basic retail stores to chemical manufacturers. Some insurers have now realized that the potential for losses in the lower categories is remote and are now opting to insure up to the first four categories without seeking the pool's reinsurance.[1]

Nevertheless, it is all too clear that the Spills Pool coverage is limited and that, effectively, the government is potentially on the hook for the payment of tremendous claims. A few of the specific concerns with the inadequacy of the protection are as follows:

- Service stations in particular are exposed to liability owing to the exclusion for bodily injury, property damage or clean-up costs caused by a pollution incident originating below the surface of the ground or water and then subsequently exposed by erosion, excavation or other means.

- A fuel spill from an unlicensed fork lift truck may be unprotected owing to the exclusion of pollution coverage from self-propelled motor vehicles. (Unlicensed vehicles cannot obtain the usual coverage pursuant to SPF#1 under the automobile policy.)

- Third parties suffering bodily injury may not be adequately compensated because of the low policy limits and the priority accorded to clean-up costs and defence expenses.

- Insurers may well react by reducing third-party automobile SPF #1 limits to the $200,000 minimum mandated by statute, and then issuing an excess policy with a pollution exclusion. In addition, they may refuse to write non-owned automobile SPF #6 insurance in order to avoid being dragged into actions.

In light of the foregoing concerns over the lack of availability and the inadequacy of coverage for environmental impairment and "sudden and accidental" pollution, the Task Force recommends that:

B.5 Consideration should be given to requiring the companies engaged in environmentally hazardous activities to set aside reserves to cover potentially catastrophic pollution events. Such reserves should be tax-exempt (see also Recommendation D.37).

B.6 The Government of Ontario should take steps to encourage the formation of an industry-based pool to accommodate currently uninsurable risks such as leaks from underground storage tanks involving fuel at service stations, home heating and oil, and industrial storage of fuel and other raw material and products.

B.7 The *Insurance Act* should be amended to make clear that insureds such as oil companies are permitted to indemnify members of their sales associate network and other non-affiliated companies and contractors in the event they suffer losses for which insurance protection is either unavailable or prohibitively expensive, such as coverage for underground tank leaks and other pollution-related exposures.

B.8 The Superintendent of Insurance should work with the insurance industry to develop adequate provision for "sudden and accidental" pollution coverage within

the Commercial General Liability policy, and if necessary, address the problem by way of minimum statutory conditions.

Legal Defence Costs

Until recently, the costs of defending against liability claims were not included within the aggregate limits of the CGL policy. Insurers traditionally controlled the defence costs by hiring their own lawyers to conduct the defence. The insurers then paid all the costs, and the full amount of the policy limits was available to pay any settlement or judgment against the insured.

Since the late 1970s, however, defence costs have escalated and, with a view to controlling costs, the insurance industry proposes to include defence costs within the aggregate limits of the policy — a practice that has already been incorporated in some other policy forms. This approach has been incorporated in the new claims-made policy form.

Obviously concerns have now arisen that in some cases defence costs may exceed the policy limits and leave nothing to satisfy the settlement or court award. Defence lawyers may also urge settlement in inappropriate cases simply in order to prevent defence costs from consuming all available coverage.

In the United States, the ISO has proposed limiting defence costs to 50% of the aggregate limit, but the National Association of Insurance Commissioners has urged states not to approve the ISO proposal until the proposal can be studied by the commissioners.

The Task Force is likewise concerned with the implications of such developments in respect of defence costs and recommends that:

B.9 The Superintendent of Insurance should examine the treatment of defence costs under the Commmercial General Liability policy and, if necessary and appropriate, make recommendations to the government for appropriate action to enhance the protection of the insured.

Responses by Insureds

The current market has caused many organizations to examine closely the cost of liability protection and the alternatives that might be available. This cost includes actual insurance premiums paid to outside insurers, self-insured losses (e.g., deductibles and captives), loss prevention expenses and associated administrative costs.

Each one of these components had to be addressed, but one of the most important management decisions was the extent to which risk was to be retained by the organization in the form of deductibles or restrictive coverage. The acceptable exposure on any one particular risk had to be considered as well as the total exposure on all risks. Changing retention and exposure levels affected each cost component mentioned above.

Following the review of costs and current and anticipated market availability, some organizations may simply decide to accept higher premiums, increased deductibles and reduced coverage. For example, in 1985 one Canadian utility paid $18,000 for $2,500,000 of primary coverage under a general liability policy. The company's assets and retained earnings were substantial. The only quotation received for 1986 was $46,000 for $1,000,000 of primary coverage. In this case, the increase in premium was meaningless in relationship to income, assets and gross revenue. Nor was the reduction in primary coverage of great concern. In summary, this company noted that premiums had more than doubled in one year but accepted the increase.

Many companies likewise adapted to the new pricing and terms. Even though premiums have increased significantly from a percentage point of view, the actual cost in dollars has not warranted serious review of alternatives. The premium cost and increased exposure continues to be immaterial to the company. Based on a small, but probably representative, sample of companies in this position, premiums for liability insurance renewals represent less than

1/5 of 1% of before-tax income.

At the other extreme, however, many organizations have found the increased premium cost and exposure to be very considerable. For example, one Ontario manufacturer of a product considered to be high-risk by insurers and exported to the United States had to increase the selling price of its product by more than 40% just to cover the increase in liability-insurance-related costs. Product liability insurance costs and exposure to product liability suits are the major financial concern to the company and a threat to its very existence.

Many organizations fall between the two extremes. The increased cost and exposure are significant but not devastating. The anticipation of a continued tightening in the market and the possibility that adequate coverage may not be available at any price are ongoing concerns.

Organizations in this position have investigated alternatives to the "normal" commercial general liability policy. These alternatives include captive insurers; retrospectively rated premiums (i.e., based on actual loss experience); group, industry and association pools or captives; administered fund arrangements; claims-made policy forms (as opposed to occurrence form of policy); higher deductibles; and lower aggregate limits. In most cases, the alternatives examined require greater risk retention by the organization and, consequently, loss prevention has become much more important.

Unfortunately, there are certain obstacles to many of these alternatives. The "single-parent" captive-insurer approach faces three major problems — taxation, legislation and aggregate stop-loss reinsurance. Following the Consolidated-Bathurst Limited case, there is now considerable doubt as to the deductibility of the premium paid to the captive for Canadian tax purposes unless the captive is a bona fide insurance body with separate management. Furthermore, amendments to the foreign affiliate rules in the Canadian *Income Tax Act* have removed many of the advantages of using offshore captives located in tax-haven jurisdictions by taxing certain income as earned (rather than as received). Statutory capitalization and other requirements under both the Ontario and federal insurance acts effectively preclude a company based in Ontario or Canada. Even if these problems can be resolved, aggregate stop-loss reinsurance to cap losses in the captive are generally not available.

Retrospectively rated premiums certainly make sense, but the concept has been abused, transferring very little real risk and becoming highly questionable from a tax point of view. These arrangements have not generally reduced exposure, and many are intended to address the problem of tax deductibility with respect to self-funding.

The formation of group, industry and association captives is equally problematic, even if they are properly structured and independently managed so that the tax problems can be resolved. The reinsurance availability problem still remains. But the most difficult problem encountered is the reluctance of the members to actually share each other's losses and the reluctance to transfer real risk among the participants, particularly where the members compete openly in the same marketplace. A group captive structured as a number of individual cells where no risk is transferred does little to reduce exposure and, if carefully examined, does little from a tax point of view. To date, few group captives have actually been set up by Canadian organizations, and those that have been formed are usually offshore, given Ontario and federal capitalization requirements.

Buying or arranging insurance through a trade association or group has certain advantages and is currently being investigated by many organizations. Some companies have decided to "go bare" (i.e., without insurance) or be underinsured. A few of these companies have stripped assets from their limited liability companies in an attempt to limit losses should financial failure result from large claims. Others have considered segregating higher-risk activities in another corporation (which could be abandoned if adverse circumstances arise).

Organizations unable to obtain mandatory minimum levels of liability insurance coverage in order to operate are considering arrangements that provide the required coverage for a premium slightly in excess of maximum exposure under the policy (i.e., the million-dollar premium for the million-dollar coverage). This allows the insured to produce a liability policy and continue to operate, but little else. These policies are clearly expensive given the meaningless value of the policy, and most insurers have been very reluctant to become involved with these arrangements. But some pressure has been put on insurers by brokers on behalf of uninsureds, in order to provide a policy to allow the organization to continue to operate while the broker tried to find a more conventional policy.

Some companies have found success by changing agents or brokers as the new agent or broker may have had access to different underwriters. This reflects the accessibility problem discussed in Part C in respect of the distribution system.

In most cases, there has been an attempt to balance the cost of the policy and exposure on self-retention (generally in the form of a higher deductible). As a general rule, the higher the self-retained risk (or deductible), the lower the premium. In the soft markets of the past, deductible levels may admittedly have fallen too low. In the current market, a much higher deductible may be warranted from an overall cost point of view. But if the deductible exposes the insured to too great a risk, consideration must be given to the creation of a facility to share the risk on the increased deductible with others in a similar position. This and other new mechanisms will be discussed later.

Developments in the United States

Problems similar to those in Canada occurred in the United States long before they surfaced here. Liability insurance coverage for municipalities, health-care entities (including day care centres and nursing homes) and taverns is difficult to obtain in the United States.

The insurance industry in the United States is subject to regulation by the individual states. In an effort to deal with the availability and affordability crisis, individual states immediately acted to assist industry groups in finding coverage. Critics' initial demands for federal regulation of the insurance industry were somewhat suppressed by these actions. Although the efforts of individual states helped to alleviate the availability problem in the short term, it was felt that further action was necessary to solve the availability and affordability crisis in the long term, perhaps through federal action. Steps are currently underway to increase capacity through amendments to the federal *Risk Retention Act* of 1981. The amendments would make it simpler for businesses, trade groups and municipalities to form captive insurance companies or pools and/or purchase liability insurance as a group.

As a first step to deal with the lack of insurance coverage many industries were facing, some states passed new regulations with respect to non-renewals and to prevent insurance companies from cancelling policies in midterm without adequate notice. Critics, however, felt that such actions would make insurers more reluctant to write risks in those states, and would cause some to leave states, thereby adding to the lack-of-capacity problem. One state proposed legislation that would allow it to regulate property and casualty insurance rates and vowed to push it through this spring. Another state granted immunity from civil suits to taverns selling liquor to a person who subsequently injures another while impaired. Most states have established voluntary market assistance programs to help industries and municipalities find insurance where coverage is not available. Such programs have been very successful.

The federal government is currently reviewing a wide range of federal product liability and tort reform bills and, most recently, the "Report of the Tort Policy Working Group on the Causes, Extent and Policy Implications of the Current Crisis in Insurance Availability and Affordability", submitted in February 1986. This report has concluded that developments in tort law are a major cause for the sharp premium increases for liability insurance. Four particular areas of concern were singled out for special attention:

- the movement toward no-fault liability, which increasingly results in companies and individuals being found liable even in the absence of any wrongdoing on their part;
- the undermining of causation through a variety of questionable practices and doctrines that shift liability to "deep-pocket" defendants, even though they did not

cause the underlying injury or had only a limited or tangential involvement;

- the explosive growth in the damages awarded in tort lawsuits, particularly with regard to non-economic awards such as those for pain and suffering, or punitive damages; and,
- the excessive transactions costs of the tort system, in which virtually two-thirds of every dollar paid out through the system is lost to attorneys' fees and litigation expenses.

This issue of tort reform and its applicability in the Canadian context will be addressed in detail in sub-Part III below.

Proposals for New Facilities and Enhanced Capacity

The following discussion will set out a series of new mechanisms and other reforms designed to enhance capacity in the critical area of liability insurance. The implementation of proposals involves no changes or only modest changes in legislation. The Task Force wishes to emphasize that, in putting forward a variety of recommendations, it is not expressing a particular preference for one mechanism or another, unless otherwise indicated. Clearly, the suitability or propriety of each will depend on a variety of factors such as the nature of the participants and the risk to be insured.

Several preliminary observations are perhaps useful. Firstly, it is preferable for the insured to stay within the insurance system rather than go offshore. Otherwise there will be no benefit from the Superintendent's regulation, and the risk base in Ontario will be diminished, thereby reducing the effective pooling of risks so critical to the insurance mechanism. Secondly, as a general matter, it is desirable to promote a healthy insurance industry in Ontario. Finally, self-insurance programs must be monitored closely, since an ill-conceived plan may endanger the financial position of both individuals and business organizations and provide inadequate protection to third parties.

Reciprocals

Reciprocal insurance exchanges are an important mechanism for generating additional capacity and can be implemented pursuant to Part XIII of the *Insurance Act*. Such an exchange is an unincorporated group or pool of individuals or organizations that contract with each other to spread the risk and losses inherent in their activities.

If one member suffers a loss, the others contribute toward the payment of that loss, based on a pre-agreed formula. The members, usually called subscribers, traditionally cover any losses by paying some premiums up-front, and agreeing to be assessed for the amounts in excess of that premium. The exchange is accordingly a form of mutual insurance that can be attractive to certain groups of organizations who have certain activities in common. It is limited to property and casualty insurance.

Very few such organizations ever existed in Ontario, probably because until recently, reasonable insurance was available. There is, however, increased activity in the formation of such exchanges at the present time.

A special report on reciprocal insurance exchanges has recently been prepared by the Financial Institutions Division of the Ministry of Consumer and Commercial Relations. Entitled "How to Set up a Sound Reciprocal Insurance Exchange", it deals specifically with publicly supported organizations such as municipalities and hospitals.

The Task Force believes that commercial enterprises should likewise be encouraged to establish reciprocal insurance exchanges. An exchange, for example, might be the most appropriate vehicle with which to ensure higher deductibles in particularly problematic areas such as libel and slander insurance coverage for newspaper publishers.

The Task Force recognizes, however, the problems arising from confusion over the tax treatment of such reciprocal exchanges. There appears to be a general lack of understanding of the true legal nature of a "reciprocal insurer" involving an unincorporated entity, subscribers and the attorney-in-fact. In addition, the taxation of the exchange (i.e., who is taxed and how) is frequently subject to inconsistent administrative application by the tax authorities.

The Task Force therefore recommends that:

B.10 The Superintendent of Insurance should continue to encourage the establishment of reciprocal insurance exchanges in appropriate cases, and should prepare a booklet describing the nature of reciprocal exchanges, their potential advantages and the statutory requirements under the *Insurance Act*, designed more specifically for commercial entities.

B.11 The provisions of Part XIII of the *Insurance Act* should be updated and clarified with respect to the obligations of subscribers or members of reciprocal exchanges.

B.12 The Superintendent of Insurance should request a ruling from Revenue Canada on the taxation of reciprocal exchanges and make available a commentary prepared by Revenue Canada to interested persons.

Insurance Pools

As noted above, groups of insurers have recently banded together to form pools as a means of providing coverage for difficult-to-place liability risks. The first such pool was created in November 1985 to provide coverage under the newly proclaimed *Environmental Protection Act*. It is known as the Spills Pool and has over twenty subscribing insurers. The pool has a common rate manual, and all subscribing insurers join in the insuring agreement. Coverage is restricted to $1 million.

In January 1986, because of difficulties in placing certain liability coverages, an additional pool was created. The OLI pool consists of some 25 companies banded together in a subscription policy arrangement to provide coverage to small businesses and non-profit organizations. It provides up to a maximum of $1 million per incident and a total annual limit of $1 million. The broker referring the business is paid a 5% commission. The OLI pool was intended as a temporary arrangement to deal with transitory difficult problems under "hard-market" conditions.

There is no doubt that this pooling mechanism and, more generally, the Market Assistance Program have proved invaluable in addressing the problem of availability for many volunteer and non-profit groups and small and medium-sized businesses exporting to the United States. It has not and cannot, however, address problems of affordability and adequacy. Nevertheless, some pools should be viewed as potentially valuable longer-term instruments to be used, albeit for limited purposes, in difficult areas of liability insurance coverage.

There is no legislative amendment necessary to prohibit or inhibit the establishment of further or additional OLI pools, as the occasion may arise. The insurance industry accordingly has the capability to maintain and operate such pools, until such time that acceptance of risks by individual companies is resumed. It may well be that the pools will be disbanded, or certain risks can be taken from the pools. Undoubtedly, the experience of the OLI pool will dictate whether it should continue to exist at all or in some changed form.

Mention should also be made of the other pooling-related efforts on the part of insurers to expand capacity and fill in gaps in availability in other areas. For example, joint underwriting has been facilitated by the formation of the Canadian Industrial Risk Insurance (CIRI) Association. The Canadian Industrial Risk Insurance Association was formed in 1973 by 30 stock insurance companies to provide a facility for wide participation of Canadian insurers in a risk-sharing mechanism that emphasizes co-operation in loss reduction services. By 1979, it ranked among the top 15 groups in Canada writing property and casualty insurance. In addition to the Canadian Industrial Risk Insurance Association, there is the Factory Mutual System, consisting of three insurance companies that provide a similar facility. Such industry mechanisms are clearly valuable and must be encouraged.

The Task Force believes that *ad hoc* industry-based insurance pools have proved valuable for addressing capacity crunches and will likely continue to be necessary for the most difficult liability risks as they emerge. Moreover, based on the positive record of the Market Assistance Program and the hot-line service, it is clearly preferable to restrict the government role where necessary to that of animator and facilitator. In this connection, the Task Force does not recommend that the government opt to mandate joint underwriting associations in certain lines, as various U.S. states have done in respect of medical malpractice.

Nevertheless, a somewhat stronger government role may be required in special cases. For example, the case of the recent greenhouse disaster demonstrates that the government itself may have to step in as the reinsurer of last resort where the industry capacity is simply not available and public interest so dictates. The ever-increasing number of environmental risks, nuclear power hazards and other possible catastrophes clearly fall into this category as well.

The Task Force therefore recommends that:

B.13 The insurance industry should be encouraged to continue to adopt pooling measures as required from time to time.

B.14 The Government of Ontario should continue to be prepared to act as the facilitator of industry-based insurance pools when capacity crunches emerge from time to time.

Export Liability Insurance Pool

As noted earlier, the Task Force believes that there are compelling reasons to justify a stronger government role in assisting the insurance industry to meet the demand for liability insurance for exports to the United States. The deep concerns in this area were highlighted in a letter to the Task Force from the Honourable Hugh P. O'Neil, the Minister of Industry, Trade and Technology:

> Clearly, we cannot continue to have the success of some of our more competitive firms jeopardized by the lack or high cost of insurance. This results in the loss of exports and jobs. It is impossible to estimate the potential losses but they could be substantial. Given that the problems are not amenable to early solution, consideration should be given by the Task Force to what measures can and should be taken both by the insurance industry and government. In this regard, it may be possible for groups of insurance companies to pool product liability risks, especially for exporters to the United States. This is unlikely to reduce the affordability of coverage. To be successful, such an initiative might have to be supported by government involvement. In this case government could either assume a portion of the pooled risks or provide limited reinsurance, without any element of subsidy, to the insurance pool. The Task Force should also consider what can be done to further develop an Ontario-based reinsurance industry.
>
> The Ministry of Industry, Trade and Technology recommends therefore that the Task Force give high priority to the insurance problems confronting Ontario businesses, especially in the area of product liability insurance for exports to the United States. There is an urgent need to deal with this crisis, and we urge you to consider immediate measures, as well as the long-term social and institutional changes which may be necessary.

The Task Force believes that the pooling mechanism might be most effective in addressing the availability, adequacy and affordability concerns in this area. It is important, however, to consider the implications of any government action for Canada's commitments under the General Agreement on Tariffs and Trade, and the need to avoid any semblance of a subsidy, since this would simply invite immediate countervailing action by the Americans. In addition, the Task Force is of the view that any action should take a national rather than a narrowly Ontario point of view. Efforts should be made to involve the federal government, particularly since many exporters operate beyond the boundaries of Ontario. However, in view of the importance of such insurance to the Ontario economy, if federal action is not forthcoming, Ontario should help create the required facility, which could serve Ontario and broader national interests as experience develops.

The Task Force considered the possibility of using the Export Development Corporation (EDC) as the appropriate vehicle for a government role. The purpose of the EDC is to provide financial services to Canadian exporters. At present, the EDC role is primarily credit- and performance-related, and does not involve product liability insurance. The Task Force has concluded, however, that the EDC vehicle is not appropriate, given the high probability that its activities would be viewed as unfair trading practices.

Other options include a direct government facility (federal or provincial); a government-sponsored pool; a pool sponsored by the insurance industry; and an export industry pool. The Task Force is pleased to learn that the government has already been examining such options on an urgent basis. It would seem appropriate to try to tailor the option to minimize the direct government role and therefore the chances of being accused of illegal subsidization under GATT. The Task Force therefore recommends that:

B.15 The Government of Ontario should give strong consideration to sponsoring an insurance industry pool, the terms of reference of which will be carefully drawn up so as to restrict assistance to those exporters experiencing a severe availability, adequacy and affordability crunch, and to avoid any appearance of subsidizing inefficient producers and manufacturers. The pool should be administered by the industry and include a hot-line service. Government financial assistance might be provided by way of reinsurance of the last resort, or guarantor of retrospective rates and excess losses when the capacity even within the pool proves inadequate and where the situation so demands in accordance with prearranged guidelines.

New Mutuals

The *Corporations Act* of Ontario provides for the incorporation of mutual or cash mutual insurance corporations that can be licensed under the *Insurance Act*. The mutual insurance corporation is probably one of the first examples of corporate co-operative legislation. It operates on the principle that each member who is insured is entitled to one vote. Capital requirements and rules of operating are the same as for a joint-stock insurance company licensed in Ontario.

It is therefore a viable alternative to individuals or corporations who have a common goal in securing liability insurance and are concerned about the lack of limited liability associated with a reciprocal insurance exchange.

The Task Force therefore recommends that:

B.16 The Superintendent of Insurance should ensure that greater information on the possibility of creating mutual or cash mutual insurance corporations, as viable mechanisms for expanding capacity, be provided to the public.

Expansion of Farm Mutuals

There are some 51 farm mutuals licensed under the *Insurance Act*, many of which have been in existence for over 100 years. They provide insurance to nearly 85% of the farms in Ontario. The farm mutuals are well organized, with their own reinsurance plan and with a guarantee fund to protect their insured members from insolvencies.

Mutuals originally wrote only fire and lightning insurance for their members. Since the 1950s, their underwriting has extended to include various other perils and eventually liability insurance. They now provide automobile insurance and environmental protection insurance to their members.

By reason of safe investment strategies, farm mutuals have built up a considerable surplus — in the order of $150 million.

The Task Force believes that one mechanism to expand capacity would be to permit the farm mutual companies to compete on an equal footing with other insurance companies for non-agricultural business. This step has already been recommended by the Dupré Commission and has been under consideration by the government for some time. Provided that the farm mutuals are subject to the same regulatory and supervisory requirements to which all other companies are or will be subject, and provided that an acceptable compensation fund mechanism is also in place, there is no reason why the appropriate amendments to the *Insurance Act* and the relevant federal legislation should be delayed any longer.

The Task Force therefore recommends that:

B.17 The proposals of the Ontario Mutual Assurance Association should be proceeded with as quickly as possible. These proposals will give farm mutuals the same investment powers as other insurers, and the ability to form subsidiaries designed to provide commercial and urban insurance coverages. Such subsidiaries should be subject to capital requirements, regulations and taxation comparable to those applying to joint-stock property and casualty insurers. At the same time, the guarantee fund of the farm mutuals must be extended to their subsidiaries to ensure adequate protection of the public.

B.18 Farm mutuals should also be required to conform to the same rules for financial reporting and disclosure as other insurers.

Extended Functions of Captive Insurers

Some use has been made by larger businesses in Canada of captive insurance companies. The primary purpose for most captive insurance companies is to provide a pool of funds from which to pay the insured's claims. The captive is also used as a focal point to establish a pool of risk in the hopes of being able to obtain reinsurance.

These arrangements for corporations and generally their affiliated companies permit the placing of insurance for corporate needs. Except for automobile insurance, which must be placed with licensed insurers, any person in Ontario is free to purchase insurance outside the province, for his own needs. The advantage to the insured is obvious, in that there is ability to structure a tailor-made insurance program and capacity can be assured. Premiums remain a deductible expense in doing business.

Special legislation exists in several American states and in a number of offshore countries, such as Bermuda. This special legislation recognizes that certain insureds do not need the regulatory protection offered to the general public. In most instances, the usual insurance-type investment clauses are not applicable. An additional attraction is that the income earned on investments by the captive insurer may not attract tax in the domicile of the parent owner.

In instances where captive insurers insure other third parties, it is customary to do so by a reinsurance arrangement with a fronting licensed insurer.

Captives may also be considered as an alternative in providing insurance to other than their owners or affiliates. Current provisions of the regulations made under the *Registered Insurance Brokers' Act* of Ontario allow brokers to place, under certain conditions, insurance with unlicensed insurers — more particularly, when "sufficient insurance cannot be obtained at reasonable rates on a form of contract required by the member of the public from insurers licensed under the *Insurance Act*". The owners of such captives might well consider extending their sphere of operation to provide insurance coverages under these arrangements to other than their own persons.

The Task Force is of the view that increased use of the captive insurer mechanism would be an effective way of expanding capacity, particularly in the more intractable problem areas of the liability insurance sector. In particular, if professional and product liability insurance needs can be met under appropriate terms for particular corporations, then greater capacity will be available in the conventional insurance market for consumer coverages and less hazardous risks.

It would be preferable, however, to encourage captive insurers to remain onshore. This could be accomplished, for example, by permitting the deferral of income tax on retained earnings until such profits are distributed as dividends. Rules and limitations to avoid abuse would be required. Such a step would necessitate the legislative reversal of the recent decision in the Consolidated Bathurst case that held that premiums paid, for example, by a Canadian company to a controlled captive will not be deductible for tax purposes (although premiums paid by a Canadian company to a captive owned by a foreign parent may be deductible). In addition, at the moment, under the *Income Tax Act*, a Canadian company is taxed on its share of a captive's underwriting and investment income (to the extent that it relates to Canadian risks), if the captive is considered a controlled foreign affiliate.

In light of the foregoing, the Task Force recommends that:

B.19 The Government of Ontario should take steps to facilitate the formation of domestic captive insurance companies and the *Insurance Act* should be amended to extend to such captive insurers. The new provisions should permit sophisticated buyers of insurance to form their own insurance companies with a minimum of regulatory oversight.

B.20 Revenue Canada should be requested to review its position vis-à-vis captive insurers, and the federal government should be urged to make any appropriate changes to the *Income Tax Act* if necessary.

Self-Insurance

Many corporations retain the responsibility for their risks by establishing self-funded reserves. In such instances, corporations endeavour to retain the portion of the risk compatible with their own risk-bearing capacity. In short, they settle their own claims out of their own funds. In most instances, they provide for a form of excess insurance for losses sustained over a certain amount.

The Task Force believes that self-insurance is an increasingly appropriate longer-term response to capacity constraints, especially for large public bodies and for specialized lines of liability, provided that the amount of risk retained is within the limits of the risk capacity. In this connection, in a paper prepared for the Task Force, Marsha Chandler and Carolyn Tuohy set out the following useful assessment of the trend to self-insurance:

> Informal provisions for self-insurance have the advantage for the insuree that they avoid insurance company loading factors; and, for low-risk insurees, they also avoid

the need to share in the expected claims costs of higher-risk members of an insurance pool. From a social point of view, however, self-insurance, especially for liability losses, presents several problems. Most notably, it may fail to protect third parties, including consumers not sophisticated enough to demand "tied packages", that is, products or services backed by insurance. It may also raise problems of adverse selection in which lower risk entities self-insure, and higher-risk entities remain in the insurance market, driving up premiums and driving even more entities at the lower end of the risk spectrum to self-insure.

Although self-insurance by individuals or individual firms may not be desirable from a social perspective, it may nonetheless be appropriate for government to encourage the formation of self-insured groups. These groups could take a variety of forms. One variation has been noted above — the suggestion that groups within the same risk class form pools for the purpose of taking on large deductibles, essentially treating conventional insurance as reinsurance. Such groups would function over time as more knowledgeable consumers in the insurance market, and as organized consumer counterweights to industry interest in the political arena (the increasing trend for large U.S. corporations to withdraw from the U.S. health insurance market in favour of self-insurance provides a somewhat analogous illustration of the gains in economic and political power to be made through self-insurance). (Etheredge, 1985.)

Another variation on group liability self-insurance mechanisms is presented by "protective associations" on the model of the Canadian Medical Protective Association, which are committed not only to pooling but also to reducing the risk of loss to their members. The CMPA decides which malpractice claims it will settle out of court, and which it will force to the courts; and provides legal services to its members as well as compensation for liability losses. It has been argued that the CMPA has reduced its members' losses by holding to a very restrictive definition of liability, and forcing any challenges to that definition to be litigated at potentially high cost to the plaintiff (rather than by monitoring the quality of its members' practices). It nonetheless demonstrates one model of self-insurance which, together with features of the Canadian tort liability system, has contributed to markedly lower costs of medical malpractice insurance in Canada than in the U.S.

One particular area where the Task Force believes that self-insurance should be positively encouraged is in respect of large corporations and the retention of more responsibility for their own risks. To this end, tax changes must be made to allow corporations to take tax deductions on "self-funded" reserves in the same way that an insurance company can on its claims reserves. (At present, a "self-funded" organization can only take a tax deduction at the time a claim is actually paid.)[2]

Three important benefits expected to accrue from greater self-funding are:

(1) More insurance capacity would be freed up for those smaller business entities and/or individuals whose lower risk-bearing capacity render them more dependent on insurance.

(2) More insurance capacity would be freed up for new types of coverage needed to respond to our changing environment and for catastrophe coverage.

(3) Greater levels of risk retention would, at least in the long run, lead to greater attention to loss prevention and control, which will benefit both the individual corporations and society as a whole.

In addition, other long-term benefits for society would be realized. In the area of pollution liability, for instance, where insurance coverage is difficult and sometimes impossible to obtain, it could clearly be beneficial to society if companies with a high pollution liability exposure were able — or even required — to set aside in a trust fund sums of money to cover the costs they will eventually have to pay for the damage they are causing to the environment. If this did nothing more than focus the attention of industrial companies on the "bottom-line" impact of environmentally damaging processes, it could be of considerable benefit.

The Task Force therefore recommends that:

B.21 The Government of Ontario should request the federal government to amend the *Income Tax Act* to permit corporations to take tax deductions on self-funded reserves in the same way that an insurance company can on its claims reserves.

Insurance Exchange

Another means of ensuring adequate capacity is to ensure the availability of adequate reinsurance. In general, it can be said that reinsurance fulfils two functions. It shifts risks from an insurer whose solvency might be jeopardized if it retained too much risk. And it shelters primary insurers against major losses and therefore tends to stabilize profits and losses of insurers, permit more orderly growth and protect capital for expansion.

There is a danger, however, in primary insurers becoming excessively reliant on reinsurance, particularly that provided by unregistered reinsurers, who rapidly disappeared at the onset of the crunch in 1986. This became all too clear with the five recent insolvencies of general insurers in Ontario, all of which had failed to retain sufficient amounts of the risk. Clearly, limitations on the use of unregistered insurance and increased minimum retention ratios are desirable, and recommendations to this end have been set out in Part D.

The source of the recent reinsurance capacity crunch, which culminated in the expiry and non-renewal of reinsurance treaties on December 31, 1985, appears to be primarily related to the extreme unpredictability of court awards and settlements in the United States. Offshore reinsurers are simply convinced that the Canadian legal system does not differ substantially from that in the United States and are firmly of the view that the developments in professional and product liability, in particular, will inevitably find their way into Canada.

The following report of a series of meetings with reinsurers at Lloyd's in April is illuminating:

> One of our problems in Canada, particularly in Ontario, is that we just do not have a broad enough economic or capital base. For example, there are simply not enough risks of a certain homogeneous type to achieve a spread. The example of providing fidelity insurance coverage to Canadian banks was cited. Here, there are relatively few Canadian banks and yet they require a minimum of say $25 million coverage of this nature. Such a coverage entails a premium of say $2 million a year, if the coverage is limited to the few Canadian banks. A similar level of coverage in the United States of $25 million a year would result in total premiums well in excess of $25 million a year. Consequently, since the ratio of premium to coverage is so important, Canadian banks are lumped in with American, European and indeed Far Eastern banks. Thus, it is quite natural in insurance terms to join Canadian experience with that of its immediate neighbours, when considering specialty lines of insurance.
>
> More importantly, Canadians export manufactured products into the United States and these products are subject to product liability. In addition, Canadian bus lines, trucking companies and other Canadian enterprises habitually trade into the United States. Furthermore, Canadian tourists visit the United States and Americans visit Canada. The fortunes of the two jurisdictions are too closely tied to effect a proper distinction from an insurance standpoint for liability coverage.

> Individuals in the London insurance market recognize that Ontario has separate and distinct legal and judicial systems. They are also aware of our well-developed social welfare system. Underwriters at Lloyd's recognize this distinction, but it is overshadowed by the need to spread risk and the strong connection of Canada with the United States. Consequently, from an insurance standpoint, risks in Ontario are seldom distinguished by underwriters in the London market from those in the United States of America.

In light of the foregoing rather gloomy prognosis for the return of reinsurers to the North American market, the Task Force believes that steps must be taken to accelerate the establishment of the proposed Canadian Insurance Exchange. It is the understanding of the Task Force that sufficient expressions of interest have now been received from potential investors to create a usable exchange and that this capital is from other-than-traditional insurance sources.

While the Canadian Insurance Exchange, through its syndicates, will not be limited to reinsurance, the Task Force is of the opinion that a reinsurance facility for Canadian primary insurers within its operations would be a logical development and would have the benefit of made-in-Canada underwriting. In addition, the Exchange syndicates could write directly more difficult-to-place commercial risks.

As is the case with Lloyd's of London, the exchange will bring together insurance capital and the expertise of many underwriters and could go far to provide much-needed reinsurance capacity within Canada. In addition, as noted by Robert Hilborn, Chairman of the Insurance Exchange: "The new facility would create employment, enlarge the province's tax base, enhance Ontario's reputation as a financial centre of international significance and create a source of Canadian-controlled reinsurance to write specialized risks".

The Task Force therefore recommends that:

B.22 The Government of Ontario should take immediate steps, with the support of its federal and provincial counterparts, to establish the Canadian Insurance Exchange in time to take advantage of the reinsurance treaty renewal period commencing January 1, 1987.

III THE CALL FOR TORT REFORM

Blaming the Courts: The American Spill-Over

In the more than two hundred briefs and position papers received by the Task Force, one message became very clear: a growing number of Canadians believe that high court awards are a primary cause of the current liability insurance crisis. This was a constant theme — both from insurers and from insureds. The concern was voiced again and again that the court system, particularly in the personal injury area, has grown out of control: that there has been a explosion in the size of liability awards, largely imposed by compensation-driven judges searching for deep-pocket defendants. Indeed, in a recent Gallup Poll released on March 31, 1986, 33% of the persons polled believed that escalating court awards were largely to blame for the current insurance crisis.

These opinions were undoubtedly influenced by developments in the United States. Research conducted for the Task Force in this area reveals that in recent years the American tort system has undergone a "dramatic transformation".[3] There has been a virtual explosion in liability and liability litigation. Multi-million-dollar jury awards are now commonplace, and American courts continue to expand traditional notions of negligence to new areas of activity and injury. The Trebilcock study found that in the United States, "the liability insurance crisis. . . is not a contrivance of the insurance industry, but in large part reflects an explosion both in the parameters and quantum of liability in the U.S. court system".

In a study released by the United States Department of Justice in February, 1986, the Tort Policy Working Group concluded that American tort law was "a major cause of the insurance availability and affordability crisis". The Tort Policy Working Group found that extreme uncertainty had been created in the tort litigation/liability insurance system through rapidly changing standards of causation and liability. The study further found that "the rules of the game have become so unpredictable that the insurance industry often cannot assess liability risks with any degree of confidence". The consequence was further unpredictability and increasing controversy.

The growing consensus in the United States that the tort system is in large measure responsible for the crisis in liability insurance has prompted wide-ranging demands for the reform of the tort system. Today hundreds of bills for tort reform are making their way through the state legislatures, and both houses of Congress. Although they vary in substance and style, the basic message remains the same: legislative intervention is needed to rein in the American tort system.

The proposals for reform advanced by the Tort Policy Working Group are typical of the reform measures that are being proposed in the various state legislatures today. They include the following:

- placing legislative limits or "caps" on jury awards for such intangible or non-economic losses as "pain and suffering";
- placing similar "caps" on the award of punitive damages;
- abolishing the doctrine of joint and several liability except in those cases where the co-defendants have acted in concert;
- abolishing the recovery of collateral benefits; and
- substantially regulating the contingent fee system.

In essence, these and other related proposals are concerned primarily with limiting or restricting the amount of damages that American juries can award for pain and suffering or for other equally intangible but more punitive objectives.

These much-publicized American developments have undoubtedly affected perceptions in Canada as well. Even though the Canadian tort system differs in several important respects, observers could not be faulted for thinking that similar difficulties were developing in Canada as well. After all, we are a major trading partner of the United States. Many of our products are exported to that market, and consequently many of our exporters are affected by developments in American tort law.

More importantly, however, the belief that court awards are escalating or that negligence liability is expanding is not without foundation. The recent and much-publicized award of $6.3 million imposed on the City of Brampton for catastrophic injuries sustained by a young motorbike rider became, understandably, a rallying cry for American-style tort reform. In dozens of briefs, the Task Force was asked to consider placing legislative limits and restrictions upon the Ontario judiciary similar to those proposed in the United States. Many of these proposals however are rooted in a fundamental misunderstanding of Canadian tort law and the nature of the Ontario judicial system.

Ontario is Not "California North": At Least Not Yet

It is important at the outset to clarify some of the misconceptions that pervade much of the public debate about the Canadian tort system and the extent to which it can be blamed for the current insurance crisis. Although the American judicial system shares the common law tradition, the Canadian tort system is different in several important respects. The major differences are these:

- Canadian tort cases are usually determined by a judge alone and not by juries. In the United States, the injured victim has a constitutionally guaranteed right to a jury trial, and multi-million-dollar jury awards are commonplace.

- The award for pain and suffering, which remains a large component of the personal injury award in the United States, was judicially limited in 1978 in Canada to a $100,000 maximum. Given inflation, this judicially imposed "cap" on pain and suffering is now approximately $184,000.

- Punitive damages, which in the United States also constitute a significant component of the jury award in a serious injury case, are very rarely granted by Canadian courts.

- The contingent fee system in use in the United States, which arguably leads to both more speculative actions being brought and to the inflation of awards by juries that are sensitive to the net value of awards to plaintiffs, is not widely utilized anywhere in Canada and is prohibited in Ontario.

- A number of procedural devices, e.g., class actions that allow the aggregation of individual loss and play a significant role in American tort litigation, are not available in Ontario.

In sum, Ontario is not "California North". Our tort system is different. There is no need to restrain juries because juries are rarely used. There is no need to place legislative limits on pain and suffering awards because a $100,000 ceiling was imposed judicially in 1978. There is no need to regulate contingent fees or reform class actions because these too do not exist.

And yet, having said this, the Task Force recognizes that in a fundamental way, even given the formal differences described above, there are deep similarities in the developing structure of American and Canadian tort law. Although Ontario is decidedly not a California of the North today, there is every indication that it may become so in the foreseeable future — not so much in the escalation of the size of awards but rather in the continuing expansion and extension of liability. This point is developed more fully below but perhaps a brief clarification is necessary.

The inevitable tendency to track American developments in this area will not mainly be in terms of the size of the award. After all, the $100,000 cap imposed by the "trilogy"[4] in 1978 will ensure that, for all intents and purposes, even catastrophic injury litigation will be focused primarily on actual economic losses and objectively ascertained compensation needs for future care, etc. The much-publicized Brampton decision has been a source of much confusion on this point. In *McErlean v. City of Brampton*, the $6.3-million award to the young quadraplegic had two main components: approximately $3 million to compensate for actual injury, lost income and future care, costs, etc. — and another $3 million as a necessary "gross-up" to deal with the tax consequences of investing the lump sum award over a number of years. There is nothing in the Brampton case or in the other multi-million-dollar judgments that we have reviewed that would suggest that Ontario courts are awarding "too much money". The $6.3-million award in the *Brampton* case has been fundamentally misunderstood both by the media and by many who are calling for tort reform. The real controversy in these cases, including *Brampton*, is not in the size of the award. Indeed, the Task Force learned that before the court gave judgment in this case, counsel had come to an agreement that if liability was found, an award of $6.3 million was a reasonable one in the circumstances.

The importance of the *Brampton* decision and the seeds of continuing controversy lie not in the size of the award, but rather in the imposition of liability. It is here that the Ontario tort system displays an unsettling but unavoidable parallel with the American. A crucial finding in the Trebilcock study was that the current "explosion" in American tort law was not the result of judicial extensions of already-advanced American strict liability doctrines but rather the judicial extension of traditional negligence liability and its application to an ever-widening range of activities and injuries. The study found that

> the so-called "explosion" of tort liability in the U.S. in the past quarter century has been quite explicitly an explosion of negligence liability rather than a substantial extension of the spheres of application of strict liability. Many of the sectors that have recently identified problems of insurability in the U.S. are indubitably governed by negligence principles. These factors comprise all suppliers of services (physicians and other professionals, day care centres, municipalities, ski operators, bus and truck operators, etc.). The extension of liability to psychiatrists who fail to warn third parties of patients' dangerous propensities; the failure of tavern or restaurant proprietors to prevent patrons leaving their premises too drunk to drive safely; the liability of proprietors of nursing homes or day care centres for abuse of patients or children by staff members; the liability of municipalities for abuse of authority, excessive force or failure to act by police officers, or for recreational accidents occurring in the course of activities organized under their aegis; the liability of physicians for "bad babies"; the liabilities of accountants for improperly executed audits, all represent extensions of liability to particular acts or omissions through the application of traditional negligence principles.

There is every indication that similar tendencies exist in Canadian negligence law and that similar developments will occur in the future in Canada as well. The reason for this inevitable expansion of liability, even within the bounds of traditional negligence doctrine, is a matter that is intractably and unavoidably rooted in what we will later describe as the "insurance-deterrence dilemma" in modern tort law.

This point will be developed in more detail below. Suffice it to say here that the similarities between the Canadian and American tort systems will prove to be more significant than the formal differences that were described above. The differences in the future will be differences in degree, not differences in kind.

A number of briefs received by the Task Force anticipated these concerns and presented a series of specific proposals for the reform of the tort system.

Proposals to Reform the Tort System

The Task Force is particularly obliged to the Canadian Bar Association of Ontario (CBAO) for its thoughtful presentation. The reforms suggested by the CBAO were also voiced by a number of other groups and associations, which had also identified other similar areas of concern. All of these reforms were proposed in good faith as measures that would help minimize or eliminate the waste, delay and inefficiency of the present tort system and make the tort-liability insurance system more predictable and less costly. The Task Force has organized the main proposals without further attribution under the following eight categories:

(1) **Family Law Act Reforms**

The concern here is that recent family law reform measures have allowed the relatives of an accident victim to recover damages for loss of "care, guidance and companionship" in addition to pecuniary losses, not only in fatal accident cases, but also now in cases involving bodily injury. This provision, now section 61(2)(e) of the *Family Law Act, 1986*, is said to have resulted in a flood of numerous and often trivial claims by distant dependants. The proposal here is to amend this provision to limit recovery to those cases where the loss of guidance, care and companionship was shown to be "serious or permanent".

(2) Pre-judgment Interest

The concern here is that the present pre-judgment interest rules in the *Courts of Justice Act* have created particular problems in the personal injury area — that more plaintiffs are now delaying the expeditious resolution of their claim in order to increase the pre-judgment interest award and that this in turn was exacerbating insurers' difficulty in predicting reserves and overall premium pricing. To deal with these concerns, the reform suggested is an amendment to the rules that would provide that pre-judgment interest for non-economic losses in personal injury cases would not begin to run until sufficient medical information had been provided to the defendant or until the plaintiff had made himself available for medical examination.

(3) Gross-up and Structured Judgments

As noted earlier, a large part of the lump sum personal injury judgment reflects a tax "gross-up" component. The need for such a tax gross-up arises because, in certain cases of serious injury requiring long-term care, the normal award has to be increased to meet the tax obligations that will arise when the lump sum is invested. The gross-up problem does not arise, of course, where the parties agree to a "structured settlement" in lieu of a lump sum payment. Structured settlements are permitted under the Courts of Justice Act provided they are entered into with the consent of all parties. Injured plaintiffs who opt for the lump sum award (with the tax "gross-up" feature) can still do so.

The proposal which was most frequently advanced is that the *Courts of Justice Act* be amended to give courts the discretionary power to impose a "structured judgment" in lieu of the lump sum, even upon an unwilling plaintiff when the court considers it to be in his or her best interest. In this way, the difficulties and uncertainties associated with "gross-up" would be avoided, judgments in serious personal injury cases would become smaller and liability insurance premiums would become more affordable.

(4) Collateral Benefits and "Double Recovery"

The concern here is in the waste and duplication that arguably arises when courts allow injured victims the right to retain benefits received from collateral sources, e.g., private disability insurance, public assistance schemes, etc. By failing to include the collateral benefits in the calculation of the "actual" loss, courts are said to allow a "double recovery" on some of the items. The main proposal is for legislative intervention to reverse recent judicial decisions that have held that collateral benefits are irrelevant in calculating the amount the tortfeasor should be asked to pay. Other proposals would permit the retention of some benefits received from collateral sources, but not others.

(5) Joint and Several Liability

Under the provisions of the *Negligence Act*, joint tortfeasors are jointly and severally liable to the plaintiff for his injuries and thus equally responsible for the total award regardless of the respective degrees of fault or responsibility for the actual injury. The problem materializes when one or more of the joint tortfeasors turn out to be impecunious. The solvent co-defendant, who may have been only 1% to blame, will have to pay 100% of the judgment.

The proposal here is to abolish the joint and several liability doctrine so that joint tortfeasors will be liable only in proportion to their degree of responsibility. The issue, of course, is who should bear the risk of a potentially impecunious defendant — the injured victim or a joint tortfeasor. Today the *Negligence Act* places the risk of an impecunious defendant on all of the joint tortfeasors. The reform being proposed would mean that plaintiffs entitled to a damage award would have to bear entirely the risks of non-recovery.

The Task Force recognizes that this is a matter of some complexity. The Task Force also notes that the problem of joint and several liability is exacerbated in the context of professional liability. As the Lilly study shows, the imposition of concurrent liability and its juxtaposition with joint and several liability have caused serious problems for building professionals and has accentuated the need for a careful and systematic study of both of these doctrines. The Lilly study is attached in Appendix 10.

(6) Limitations

The current *Limitations Act* is an amalgam of statutory provisions from thirteen English statutes, some dating back to 1588. By any measure the current legislation is seriously out of date and in need of reform. Much of it is unintelligible to the layperson and unsuited to the needs of modern litigation. Fortunately, the Ministry of the Attorney General is presently reviewing Bill 160, An Act to Revise the Limitations Act. Bill 160 received first reading on December 16, 1983, but then died on the Order Paper. The Policy Development Division of the Ministry of the Attorney General is currently soliciting views from industry groups and organizations to see whether and to what extent Bill 160 should be modified and improved.

The concerns expressed to the Task Force relate mainly to the problem of long-tail liability. The problems are particularly acute for architects, engineers and health-care professionals.

Because the existing limitation periods (six years for tort and one year for medical injuries) run from the date of "discovery", this means liability can be imposed and damages awarded years after the actual service was performed, and in some cases even after the supplier of the service has retired and his or her "claims-made" coverage has lapsed.

The reforms proposed here are reforms to add certainty and "cut-off" to long-tail claims. The Lilly study urges that limitation legislation be amended so that the limitation period for all professionals would run from the date of the last professional service.

(7) Good Samaritan Legislation

A number of groups and organizations, particularly those in the voluntary sector, have urged that "Good Samaritan Legislation" be enacted to provide greater tort protection to volunteers providing medical assistance in good faith. Good Samaritan legislation is now in effect in Alberta and Nova Scotia. In these provinces Good Samaritans are immune from suit unless "gross negligence" can be shown. The Task Force also received proposals for application of the Good Samaritan approach beyond the realm of medical assistance.

This matter was studied by the Ontario Law Reform Commission (OLRC) in 1970. The OLRC rejected the need for a Good Samaritan statute, noting that at that time the case for such legislative intervention had not been established. In its brief to the Task Force, the Ministry of the Attorney General notes that in the intervening years there have been no reported cases where Good Samaritans or other volunteers were held liable for assisting in a medical emergency. The brief asks why such legislation is now thought to be necessary.

Notwithstanding the findings of the OLRC, the Task Force understands that the problems of insurance availability and affordability have been particularly acute in the voluntary sector. Indeed, Michigan and a number of other states are currently considering Good Samaritan legislation as a partial response to the insurance crisis.

(8) Arbitration
Finally, one of the briefs received suggested that arbitration of automobile accident benefits under the Standard Automobile Policy be instituted, at least on a trial basis, to faciliate a more expeditious resolution of the smaller automobile accident claims.

Those were the main categories of suggested reform. They were not the only reforms suggested. Scattered through the dozens of other briefs and submissions were reform proposals relating to corporate law (incorporation of professionals and hospitals' corporate liability), civil procedure (the demand for a more generalized security-for-costs rule to minimize frivolous lawsuits) and tax reform (amendments to federal tax laws to accelerate reserve build-up for professional self-insurance plans).

The Chairman's Comments on Proposals to Reform the Tort System

The Chairman of the Task Force is not a lawyer or a scholar of the law. His own comments on proposals to reform the tort system are offered with more than a touch of humility and tentativeness. But they must be offered, for whatever help they may be to public debate and action. In the end, it is the citizens, not the lawyers, who must decide to support tort reforms or choose other courses.

In the broadest sense, the choices are among an evolutionary, incremental, piecemeal approach, to reform; a more fundamental, integrated, planned approach to reform; and some blend of the two. No one is satisfied with the status quo. Virtually everybody the Task Force encountered argued for change. The question is what changes and how. The Chairman believes that the main emphasis in the reform should be put on a fundamental, integrated, planned approach, for reasons to be developed in the rest of this Part of the Report. But more evolutionary, incremental, piecemeal approaches also deserve careful consideration.

In recent decades, partly as a result of legislation and regulation, but mainly through the tort-litigation system centring on the courts, change has been wrought in a gradualist, decentralized process that has attempted to reconcile the rights and responsibilities of individuals with those of society. In the work of the Task Force, the Chairman has come to respect what has been accomplished in this way in Canada and in Ontario. The concepts of tort have been interpreted and applied more widely to meet society's needs for compensation for bodily injury. The standards of compensation have been related to the changing needs and capabilities of Canadians. The standards have reflected changes in society's choices regarding home versus institutional care, and life-cycle income expectations in the country. These standards have been applied to individual cases, having regard for individual circumstances. Limits have been placed by the Supreme Court of Canada on awards for pain and suffering, limits which appear to have widespread acceptability in Canada. The outcome of the process is far from perfect, but it could have been much worse. Any other process that is used in whole or part to deal with compensation and deterrence in relation to accidents will have to deal with the same issues as the tort-litigation system has dealt with.

The proposals for tort reform are mainly modest legislative or administrative changes that would help shape the framework or practices of the tort-litigation system. They were offered as contributions to the evolutionary, incremental, piecemeal approach to reform. The Canadian Bar Association of Ontario deserves commendation for its major effort to build a broad consensus around a set of modest proposals for tort reform; it is to be hoped that that process will continue. The subjects for reform were not held out to be causes of the insurance crisis, nor the reforms as cures. Rather, at a time when the insurance crunch created the possibility of building some consensus for reform, an effort at finding useful compromises on a number of issues was made among a wide range of interests, not just insurers.

As to the substance of some of the proposals for tort reform, the Chairman offers the following comments. Regarding pre-judgment interest, it is important to note that no change is proposed in the entitlement to pre-judgment interest for economic losses; this is as it should be. Regarding gross-up and structured settlements, as will be argued later in the Report, if structured settlements to meet the cost of care are not taxable (a proper position), then neither should the equivalent lump sums to meet the cost of care be taxable. The case for more use of structured settlements is a strong one, quite apart from the issue of taxation. Consideration should be given to allowing settlements to be made by way of a contract which would deliver a program of benefits, instead of the usual detailed structure based on assumed contingency and economic projections. Regarding collateral benefits, the Chairman is inclined to disallow the right to retain benefits from public programs, at least for the improved program of auto accident benefits proposed later in this Report. To deny collateral benefits arising from private arrangements does seem improper. No additional comments are offered on the *Family Law Act*, the joint and several liability doctrine, or limitation periods.

Is Tort Reform the Answer?

Can the basic problems that confront the tort-insurance system and that in large part have caused the liability insurance "crisis" be resolved through tort reform? The Task Force has given this difficult question careful thought; indeed, it could not have done otherwise. As has already been acknowledged, in the area of personal injury compensation the tort system has played an ongoing and conscientious role. The Canadian courts have demonstrated a remarkable ability to respond institutionally when a response was required. For example, an important reason why Ontario has not become a "California North" was the sound judicial decision in 1978 to place a $100,000 cap on pain and suffering and thus to confine rigorously the otherwise arbitrary process of measuring intangible loss. The Task Force recognizes that in many areas the Canadian tort system has shown that it can be counted on to respond to the changing needs of Canadian society in sensible ways. In the last two decades the tort system — both the judges and the personal injury bar — have accomplished a great deal and have much to be proud of.

The Task Force has concluded, however, that the problems that pervade the personal injury area and that in large measure have caused the current liability insurance "crisis" cannot be resolved through further reform of the tort system.

The basic problem confronting the Task Force in the liability insurance area is threefold: availability, affordability and overall adequacy. The various proposals for reform discussed above and the even more dramatic measures suggested in the United States could conceivably improve matters, but not enough. Tort reform is not the answer for three basic reasons.

First and foremost, no strong connection has been established between any of the eight or more areas of difficulty or all eight together and the present insurance crisis in Ontario. No evidence has been adduced to demonstrate that any of these areas of difficulty are relatable to the present problems of the availability or affordability of insurance. In fairness to many of the groups that voiced these concerns, the point was made to the Task Force that such evidence would be difficult if not impossible to obtain. Nonetheless, even with the contributions of many experienced individuals, the Task Force was unable to determine the size or significance of these various difficulties or their relevance to the current insurance crisis. Indeed, many of the proposals were offered as changes that would make only modest differences to the cost and availability of insurance.

Secondly, even if some or all of these measures were implemented, there is no reason to believe that the tort system would in fact be much "improved" or that the liability insurance system would be stabilized. The evidence thus far suggests that the sensible direction for reform is not in adding *ad hoc* restrictions to the tort system but rather in the analysis of its basic rationale.

This brings us to the third and most important point. Any reform of the tort system should only be implemented when the objectives of that system have been satisfactorily identified. The growing contradiction between the deterrence objective and the compensation objective, particularly given the phenomenon of modern insurance, will be discussed in more detail below. Here, two questions will be asked. If deterrence is indeed the objective, and this objective requires that tortfeasors be exposed to *all* of the social costs of their negligent conduct and pay full compensation for injury, why is it justifiable to restrict or limit compensation awards as some of the reform proposals would do? On the other hand, if compensation is the objective, then why should recovery be limited or restricted in the ways suggested? As the Trebilcock study demonstrates, many of the tort reform proposals that are currently being considered both in the United States and in Canada are rendered incoherent when subjected to careful analysis.

Much of the problem, of course, is that the analysis is itself confused and contradictory. This in large measure is the result of what we later describe as "the insurance-deterence dilemma". But whatever it is, it is certainly clear that when the operation and objectives of the tort system are mired in contradiction and confusion, adding *ad hoc* "reform" measures that exacerbate the problem is no solution.

Some Interim Measures

The Task Force offers a more fundamental approach to tort reform in sub-Part IV below. It recognizes, however, that some time may elapse before these measures can be implemented.

Several of the proposals for tort reform set out above are sensible in themselves, even if they would not make big differences to the overall efficiency and equity of the tort system or the fundamental capacity of the property and casualty insurance industry to meet the needs of insureds. They would probably do some good, and it appears to the Task Force little harm. They need not prevent the more fundamental approaches to tort reform. Therefore, the Task Force recommends that:

> **B.23 The Government of Ontario should consider taking action to introduce changes in the spirit of the proposals reported above on pre-judgment interest, gross-up and structured settlements, and joint and several liability and limitations. The Government should consider the treatment of collateral benefits in connection with recommendations C.1 and C.2 for reform of the compensation for bodily injury due to auto accidents. The Government should give prompt consideration to the risk and liability problems of volunteers. The industry and the Government should seek to develop and apply arbitration as an alternative method of dispute resolution in accident compensation cases.**

One of the most frustrating problems for the Task Force arose from the scarcity of systematic evidence on awards and settlements and on elements in the legislation and the tort-litigation system that contributed to the determination of awards and settlements. The Task Force attempted to develop additional evidence, but had neither the time nor the resources for a successful effort. The Task Force is convinced that it is possible and economical, particularly if sampling methods are used, to gather future evidence on awards and settlements and on the factors determining their nature and size. Accordingly, the Task Force recommends that:

> **B.24 The Government of Ontario should develop and implement, with the co-operation of the industry, a statistical plan for the gathering of data and the**

analysis of awards and settlements of compensation for accidents, including the components that are used in building up overall awards or settlements.

It is desirable that the analysis of awards and settlements be reviewed periodically by a committee of the Legislature, perhaps at the time of the review of the annual report of the Superintendent of Insurance.

The tort reforms described above should be studied further. Any that are implemented soon should be tracked, and all of them deserve more careful study than has taken place to date. The studies should first determine whether these reforms have improved, or would in fact improve, the performance and predictability of the tort-liability insurance system, and second, determine which of these reforms would help meet the primary objectives of the modern tort system.

The Task Force notes that many of the items discussed above are already the subject of a major study that has just been commenced by the Ontario Law Reform Commission. The OLRC Project on Personal Injury Compensation provides an ideal opportunity for the further examination of these tort reform proposals. To this end, the Task Force will ensure that all the briefs and submissions received on these points and discussed briefly herein will be forwarded to Professor Stephen Waddams, the Director of the Project on Personal Injury Compensation, for his immediate attention.

The Task Force also recommends that:

B.25 The OLRC study should expand its mandate to include each of the eight reform areas that were discussed above. In particular, the question of joint and several liability, appropriate limitation periods, the need for Good Samaritan legislation, and the arbitration of accident benefits should be added to the OLRC personal injury study.

B.26 A parallel study should be commenced by the OLRC to address problems that go beyond the personal injury area and that relate to liability under the tort system in general, particularly in the professional liability sphere. The Task Force will ensure that the OLRC obtains a copy of the Lilly study and related briefs and papers so that such questions as concurrent liability, joint and several liability, appropriate limitation periods, incorporation by professionals and other matters raised therein can be studied in a careful and systematic way.

B.27 The work of the Ontario Law Reform Commission in both of these areas should be accelerated so that its final report can be made available as soon as possible.

IV THE NEED FOR A FUNDAMENTALLY DIFFERENT APPROACH TO ACCIDENT COMPENSATION

The Tort System in Context

Many people believe that the tort system plays a central role in injury reparation. The tort system is but one part of a multi-faceted compensation system. Most injuries are dealt with outside the court system, on a no-tort basis. In a study completed for the Task Force, Osborne describes the existing array of federal and provincial no-tort compensation programs.

The most obvious example, of course, is the Workers' Compensation Plan, which has been providing no-tort injury compensation since its enactment in 1914. Another is the Ontario Health Insurance Plan. A third is the range of no-fault benefits that have been "added on" to bolster automobile insurance coverage. Other examples are found in the disability benefits found under the unemployment insurance, Canada Pension Plan and veterans' allowance programs, provincial injury compensation schemes for victims of crime, and injury benefits that are available to many Canadians under private disability insurance plans.

For most Canadians compensation for personal injury is handled without the use of judges, lawyers or courts. Compensation is paid directly to the injured first-party on a no-tort basis. The social and economic significance of these first-party no-tort injury compensation schemes is substantial: over $5 billion is paid out annually under these programs to accident victims in Canada. The proportional importance of tort within this larger context is relatively small: of the $2.5 billion that was paid out under various Ontario accident compensation schemes in 1981 to injury victims, only $250 million was paid through tort.[5] No-tort injury compensation, or what is popularly but somewhat inaccurately referred to as "no-fault" compensation, is not a novel notion in the overall Canadian context. Indeed, for most injuries, it is the norm.

Nonetheless, it is fair to say that the tort litigation fragment continues to assume a pre-eminent role in the compensation delivery system. It continues to attract attention not because it is central but because it is inherently uncertain.

The Incoherence of Modern Tort Law: The Insurance-Deterrence Dilemma

Modern tort law, both in the United States and in Canada, has in recent years undergone a major transformation. In the personal injury area it has been dramatically transformed from a mechanism primarily concerned with deterrence to one whose main purpose is compensation. The Osborne study described this transformation as follows:

> Since the turn of the century the tort of negligence has expanded from a relatively narrow and circumscribed field of civil liability to a generalized remedy for virtually all victims of negligent conduct. The duty of care now extends to almost all persons involved in activities which involve a risk to life and limb. This expansion of the scope of the tort negligence has been accompanied by a steady reformulation of the rules of liability to withstand the scope of compensation and to minimize the difficulties of the plaintiff in proving his or her case. The development has been typically judicial — cautious, incremental and broadly within the boundaries of the fault concept. Nevertheless, the sum of the individual changes is a massive transformation of the fault system.

Both in the United States and in Canada tort law has seen the judicial expansion of negligence liability to include new areas of activity and injury. In a study completed for the Task Force, Trebilcock describes the Canadian and American developments in some detail. It is sufficient to note here that, notwithstanding the formal distinctions described earlier, fundamentally the differences between the American and Canadian tort systems are differences of degree, not differences in kind. The American and Canadian judiciaries have both learned to manipulate highly malleable negligence doctrines in order to respond to the changing needs of modern society. Both judiciaries have learned to use tort for loss distribution.

Why has this transformation taken place? Here lies the irony. The basic reason for the dramatic transformation from deterrence to compensation is the phenomenon of modern liability insurance.

> The massive transformation of the fault system . . . is a change which is explicable only on the basis of liability insurance and judicial compassion for the victims of social progress. Judges who in their written judgments give no indication of the prevalence of liability insurance are in fact keenly aware that in almost all cases the defendant is

> not paying, and that they are in the last analysis deciding whether or not the plaintiff should be compensated from insurance monies.... The prevalence of liability insurance fundamentally altered the moralistic nature of the loss-shifting function of fault. The loss-shifting mechanism was converted into a loss-spreading mechanism and it became more realistic to speak of the fault system as a fault-insurance system. The punitive and deterrent aspects of fault were diminished and compensation became the predominant function of tort law.[6]

We discuss in more detail below the reasons why insurance was bound to undermine deterrence. These findings have now been documented in the literature to which we will turn shortly. But the judiciary, in both the U.S. and Canada, seem to have recognized intuitively the implications of insurance.

Because of insurance, the analytical sequence in the judicial determination of "fault" has been reversed; rather than proceeding from a finding of liability to an award of compensation, the pervasiveness of insurance now has moved courts inevitably to look first to insurance and then to liability. The Trebilcock study found that "many judges even within a negligence regime are influenced by this revised sequence of insurance to liability in making determinations of negligence". Thus tort was effectively transformed into a system of social insurance for a wide range of societal risks, and it is the ultimate irony of the present insurance crisis that it was in the very success of modern liability insurance that the seeds were planted for the inevitable failure of tort.

With liability insurance, and a progressive and conscientious judiciary, the insurance-deterrence conundrum is made complete. The courts know they cannot deter; they also know they cannot fully and completely compensate all victims for all accidental injury. Thus, a "radical indeterminacy" is inevitably introduced into tort and, hence, an inherent instability.

In more human terms, the contradictory demands of the insurance-transformed tort system place an enormous strain upon the integrity of its judges. In a recent speech, Mr. Justice Krever of the Ontario Court of Appeal openly reflected on the incoherence of modern tort law and the inevitable pressures that sometimes lead judges into "intellectual dishonesty".[7] Mr. Justice Krever noted that judges will tend to find "fault" where none exists, so that totally innocent plaintiffs who suffer catastrophic injury can be adequately compensated by the wealthier insurers of equally blameless defendants. Mr. Justice Krever expressed a view that is undoubtedly shared by many of his colleagues:

> It is not satisfactory to continue to base compensation only on the necessity to find fault because [there] is a propensity - in those cases where there will be no real compensation, unless there is fault — towards intellectual dishonesty.

This is bad enough. But further tension is created when compensation has to be denied a seriously injured plaintiff simply because the elastic doctrines of modern negligence law have run out of elasticity and "fault" cannot be found. This happened in a recent case in which Mr. Justice Krever himself had sat as the trial judge.[8] A 58-year-old milkman was rendered a quadraplegic as a result of a non-negligently administered angiogram. He could not afford to hire help to turn him over two or three times at night as his medical condition required, and thus his 70-year-old wife had to do it herself. He could not afford to build ramps, or change the doorways where he lived, even to permit his wheelchair to be wheeled into the bathroom. The court found that "for all practical purposes, he became a virtual prisoner in the apartment". Nonetheless, despite the serious injury and the difficult consequences, Mr. Justice Krever had to deny compensation; "fault" could not be found and thus compensation could not be awarded. Mr. Justice Krever reflected on his decision:

> Here['s] a person who, through no fault of his own, entrusting himself to the health care system, became incapable of supporting himself and his wife and living an ordinary life, incapable of relieving his wife of the obligation of getting up in the night to turn him over. All of these things could have been made available by an award of damages, but you have to find fault.

He referred to his dilemma in the course of his reasons for judgment:

> I confess to a feeling of discomfort over the state of affairs in an enlightened and compassionate society in which a patient who undergoes a necessary procedure and who cannot afford to bear the entire loss, through no fault of his own, and reposing full confidence in our system of medical care, suffers catastrophic disability but is not entitled to be compensated because of the absence of fault on the part of those involved in his care. . . . While it may be that there [is] no remedy for this unfortunate and brave plaintiff and that this shortcoming cannot be corrected . . ., there is in my view an urgent need for correction.

The decision was appealed to the Ontario Court of Appeal, but the Court again had no alternative but to deny compensation. The Court of Appeal then said this:

> We [would] not want to leave this case without adding that we are in complete sympathy and agreement with . . . the learned trial judge's reasons. . . . We agree that in situations such as the instant one, "an enlightened and compassionate society", to use the words of the learned trial judge, should do more.[9]

In many ways the modern tort system, at least in the personal injury area, has reached the limits of its capacity. It cannot continue to operate as a compensation mechanism using notions of negligence or fault. This will only deepen the incoherence, instability and continuing unpredictability.

Any proposals for tort reform that continue to obscure the fundamental tension between insurance and deterrence should be rigorously resisted. The answer is not in adding illogic to incoherence, but in understanding that the tort system should not be asked to do the impossible. It cannot promote socially optimal insurance and deterrence objectives simultaneously. This is the present dilemma. There is no good reason to dig the courts into a deeper hole.

The Need For Reform

The answer lies in separating the compensation function from the deterrence function. The appropriate direction for reform would be in the design of a compensation system that works and also a deterrence system that works. Compensation should principled and prompt. Deterrence should be principled and precise.

Although we have already suggested that in the personal injury area, the modern tort system cannot be counted on to perform these separate functions simultaneously, what if measures were taken to separate the compensation function from the deterrence function and then allow the tort system to continue doing one *or* the other? Could it succeed in either area?

This matter has been explored extensively both theoretically and empirically. The literature is voluminous. Suffice it here to draw the reader's attention to the most salient conclusions on these points. First, the deterrence function.

The Tort System and Deterrence

The inability of the tort-insurance system to achieve a significant deterrence objective has been documented in the literature. In 1979, the Ontario Law Reform Commission concluded that "tort law is a haphazard and inefficient means of deterrence". In 1984, the New South Wales Law Reform Commission went even further: "It is difficult to find any empirical evidence which proves that . . . fault operates as an effective deterrent". A recent Canadian study summarized the reasons why the existing tort-insurance system cannot be expected to perform a deterrence role:

> The root assumption and one that puts into serious question the overall utility of tort law ability deterrence theory, is that our system of common law adjudication is efficient. This threshold assumption of the efficiency of our courts and their determination and imposition of liability is crucial. The precision and sensitivity (the "efficiency") required for market deterrence to be a workable concept in practice is extraordinary. What you need is nothing less than a responsive, sophisticated, perfectly informed and litigationally motivated plaintiff; a fully informed judiciary with a confident capability in differential calculus; a litigation process that precludes below-social-cost settlement practices and ensures the accurate and immediate imposition of liability upon the appropriate supplier; a suppliers' marketplace that in fact does internalize the full brunt of the liability judgment and then reflects this internalization in subsequent product-pricing decisions; and, at the very least, a sophisticated insurance industry that is technologically able to resuscitate the deterrent effect of an insurance-covered tort judgment by means of a carefully calibrated and supplier-individualized rate-making procedure.
>
> In sum, market deterrence to be at all workable requires a high degree of product information, victim initiative, judicial care and capability, supplier responsiveness, and insurance industry precision.[10]

The same study went on to explain this analysis and reiterate the many findings worldwide as to why it is that the tort-insurance system cannot and does not achieve a significant deterrent objective. The reasons include the following:

- most injured people do not sue — even when there is a reasonable basis for believing that the "fault" of another could be established;
- for the small percentage of injury claims that actually proceed to litigation the parties are soon confronted with the highly elastic doctrinal norms of modern negligence law and with the realization that "fault" is not a self-defining concept, adding further imprecision and unpredictability to the process;
- years may pass as the lawsuit winds its way through court with further delays that further dilute deterrence;
- when judgment is finally delivered and damages are awarded there is no relationship between the severity of the sanction (the damage award) and the degree of "fault";
- the judgment that is finally handed down by a well-intentioned court is rarely paid by the individual wrongdoer: in 9 cases out of 10 insurance fully absorbs the impact of the judicial decision;
- any residual impact that might notionally remain is at most by way of an adjustment or increase in the insurance premium, years later, and as a study of the New York Insurance Department concluded in its report on automobile insurance, "individual last moment driver mistakes — undeterred by fear of death, injury, imprisonment, fine or loss of license — surely cannot be deterred by fear of civil liability against which one is insured", or, one could add, by fear of a belated and imprecise adjustment in one's insurance premium.

Finally, even if these inefficiencies and obstacles could be cleared by a Herculean reform of the tort system, the question of deterrence, given the reality of modern insurance, is one that can be answered outside of tort. To the extent that modern insurance coverage means that in most situations deterrence will be achieved or will be achievable through the vehicle of premium variability or "experience rating", this very mechanism exists and can be worked into any first-party no-tort accident compensation plan. That is, deterrence via higher premium pricing or "penalty rating" is a common feature of many existing first-party no-tort schemes and could easily be incorporated and developed as a component of the no-tort scheme that we set out in more detail below.

In sum, the best evidence we have today suggests that deterrence alone cannot justify the retention of the tort litigation fragment for non-work injuries. The theoretical foundations for the tort-market deterrence model are shaky, the practical problems as described above are insurmountable and, given the pervasiveness of modern liability insurance and the need for deterrence through premium variability, the tort-deterrence debate is ultimately irrelevant.

The Tort System and Compensation

If deterrence must be discarded as a rationale for preserving tort, the only other rationale that remains and one that ironically continues to drive the tort system today, in the personal injury area at least, is compensation. Here, the modern theoretical and empirical literature in its evaluation of tort as a compensation mechanism is even more compelling. The compensation rationale, put simply, fails both in theory and in practice.

The fundamental flaw in using tort to compensate through efficient insurance principles was explained in the Trebilcock study. The study correctly observed that efficient insurance cannot be delivered by the tort system because the system yields no coherent theory of how to identify the most efficient insurer. Given this incoherence and the uncertainties attendant on it, it would be futile to attempt to reform the tort system with insurance objectives or compensation objectives as the operative criteria.

The practical difficulties of continuing to utilize tort primarily as a compensation mechanism in the personal injury area have been documented extensively. The Osborne study discusses the findings in detail and the reader is referred to it for further amplification.[11] But here a brief summary may be useful. The basic reasons why the tort-insurance system remains an ineffective and inadequate compensation mechanism are:

(1) Under tort, compensation is paid on an irrational basis. Even given the highly elastic and inevitably expanding "fault" liability doctrines, the seriously injured plaintiffs would still slip through the judicial net. For example, the 58-year-old milkman who was rendered a quadraplegic through the non-negligently administered angiogram discussed earlier should have been compensated. All of the judges hearing the case agreed that he should have been compensated, yet compensation was denied because "fault" could not be found. But if the compensation mechanism is intended to compensate for accidental injury, it should compensate for all accidental injury, whether slipping on a sidewalk, being hit by a car, or stupidly but tragically walking through a glass door.

(2) Under tort, more than half of all modern injuries go uncompensated. The best evidence that we have today indicates that only 1/3 to 1/2 of accident victims get any compensation through the tort system. Others, including those who are seriously or catastrophically injured, are left behind or slip through the cracks.

(3) Under tort, there is enormous delay. The tort system as it presently operates does not pay compensation promptly even to the winners. Evidence shows that it is not unusual for some cases to drag through the court system from 2 to 13 years. In the much-discussed *Brampton* decision, if liability is upheld on appeal, a further 3 or

4 years will go by before substantial compensation is actually paid — in total some 13 years after the accident occurred. And these are the "winners" in the system.

In a recent study, Feldthusen and McNair examined how the Canadian tort system treats the "winners".[12] They studied one of the trilogy decisions of 1978, *Teno vs. Arnold*, where the Supreme Court of Canada awarded $540,000 in damages to the parents of a severely disabled girl for injuries she sustained when hit by an ice cream truck that was driving through the neighbourhood. The case wound its way through the courts for nine years. Finally, the Supreme Court of Canada awarded the parents $540,000. Did the Tenos "win"? The Feldthusen and McNair study provides a troubling answer:

> The strength of the tort system. . . seemed to lie in how well it treats its "winners" — they are persons who not only secure a judgment in their favour, but whose lump sum award by pure chance proves adequate to meet their lifetime needs. But ask whether Mrs. Teno, with her daughter's best interests at heart, would not rationally have preferred assured future care expenses and basic income for life, payable more or less routinely without a trial in 1969, [over] almost 9 years of uncertainty and expense, culminating finally in 1978. Would not many successful plaintiffs trade the "justice" and "satisfaction" of litigation and the non-pecuniary damages for the relatively low-cost, fast and secure benefits that would be available under a no-tort compensation scheme? If this is true of the "winner" of one of the largest Canadian awards ever, what of the "losers" — the unsuccessful plaintiffs, the victims of non-tortious accidents, and the tortfeasors themselves?

(4) The present tort-insurance system, although run by a well-intentioned and compassionate judiciary, remains riddled with uncertainty and unpredictability — so much so that many commentators have described tort litigation as a "lottery". In the leading study of this question, O'Connell summarized the various factors that combine to make tort litigation very much like a game of chance.

> The operation of the tort system is akin to a lottery. The most crucial criteria of payment are largely controlled by chance:
> a) Whether one is "lucky" enough to be injured by someone whose conduct or product can be proved faulty;
> b) Whether that party's insurance limits or assets are sufficient to promise an award or settlement commensurate with losses and expenses;
> c) Whether one's own innocence of faulty conduct can be proved; and
> d) Whether one has the good fortune to retain a lawyer who can exploit all the variables before an impressionable judge or jury, including graphically portraying whatever pain one has suffered.[13]

(5) Even if all of the other deficiencies described above could be eliminated, the final one is the most serious: the inordinate financial cost of continuing to use tort for injury compensation. A large portion of every premium dollar is eaten up by the transactions costs of the tort-insurance system. More than 50 cents of every premium dollar is absorbed in the administrative and legal costs of running the system.

Less than 50 cents of the premium dollar is actually paid out in compensation under tort, compared with 80 to 90 cents that are paid out under no-tort insurance plans. As a recent Canadian study concluded:

> If you sat down to design a system for wasting and dissipating precious medical and insurance resources, you could not do any better than what we have now.[14]

The Trebilcock study came to the same conclusion:

> Compensation administered through the tort system — in large part because of the uncertainties entailed — is appallingly expensive. Victims receive only a little more than 1/3 of the monies entering the system, compared to 80 or 90 per cent under most forms of first party or social insurance. . . . As a system of insurance or compensation, the current tort system is, on most criteria, an abject failure.

In the personal injury area, tort should not be used either for deterrence or for compensation objectives. The former should be clarified and reinforced through a combination of regulatory initiatives at both the premium-pricing level (via a bonus-malus system described in more detail in Part C below) and at the public safety and Criminal Code enforcement level. The latter, compensation, should be dealt with separately in the context of a fair and more expeditious no-tort insurance system.

The importance of separating compensation objectives from quality-control concerns in the design of a modern health and safety program was stressed in a recent study that was conducted for the federal Department of Health and Welfare on the "Potential Effect of Liability Claims on the Canadian Public Health-Care System".[15] The study examined the current crisis in the health-care system and, in particular, the difficulties in the medical malpractice area: the changing nature of medical malpractice litigation, the increasing numbers of actions that are being brought against doctors, the spiralling increases in legal costs, and the growing delay in the processing and settlement of medical injury claims. The study concluded that "the civil liability system for the compensation of the disabled is cumbersome, complex and expensive" and urged that an alternative to litigation for the compensation of those disabled by medical injury had to be sought. The study said this:

> We should compensate the disabled regardless of how their disability was caused. We should ensure that their quality of life is maintained. . . . The legal system does not ensure that the disabled are compensated unless negligence can be proved. As well, the tort system does not and cannot deal effectively with the health-care professional who practices sub-standard care. Nor can it deal effectively with a negligent hospital or with negligence in the health products industry. . . . The issue of compensation for the disabled should be clearly separated from the issue of the regulatory requirements for maintaining the standards of health care. . . . An alternative to litigation for the compensation of the disabled has to be sought.

Towards a No-Tort System of Accident Compensation

The fundamental solution lies in recognizing that compensation and deterrence must be separated and that the compensation job must be done through a more efficient and equitable first-party no-tort accident insurance system. The modern-day problem of injury compensation should be dealt with more efficiently and expeditiously — not through tort but through insurance. Whether the reforms proposed below are to be instituted incrementally or more generally is a matter that must be left for the legislature. The Task Force will set out its views on this matter in more detail below.

First, however, it is important to emphasize the following three points:

(1) The *design* of the new insurance compensation system should proceed on a no-tort basis. This does not, however, mean a "no-fault" basis. Compensation, to be sure, will be provided on a "no-fault" basis, but fault will remain relevant and deterrence will be achieved through a more refined and rigorous penalty-rating or premium-pricing mechanism, as described earlier.

(2) The *delivery* of the no-tort accident compensation system should remain primarily in the hands of the private insurance industry — at least so long as private insurance can demonstrate that it has the financial capacity to design and administer such a scheme at affordable premium levels.

The basic scheme that is envisaged by the Task Force is a no-tort accident insurance policy designed and delivered by private industry, providing unlimited medical and rehabilitation benefits, including cost of care, and income replacement benefits at levels that would be reasonably adequate for the vast majority of Ontario citizens.

(3) Additional coverage for income replacement benefits in excess of the basic insurance package would be obtained on a first-party basis, through the voluntary purchase of additional "layers".

To return then to the question of degree of implementation: the Task Force sees three basic choices once the principle of no-tort accident compensation has been accepted. They are as follows:

(1) No-Tort Injury Compensation for Automobile Accident Injury Only
This would involve the redesign of the existing and compulsory automobile insurance scheme by raising the no-tort or "no-fault" benefits to accommodate the basic principle developed above and then to provide for the purchase of additional layers for those individuals who choose to obtain excess coverage above the basic norm. The province of Quebec has had a no-tort automobile accident insurance plan in operation since 1978. However, it is important to note that the Quebec scheme is government-run. The Task Force believes that in Ontario the private insurance industry should have the opportunity to demonstrate whether and to what extent it can be counted on to deliver the insurance product.

(2) No-Tort Injury Compensation For All Accidents
In many ways this is the logical reform in the redesign of the Ontario injury compensation system. If workers' compensation remains as it is — a government-run first-party no-tort compensation scheme - and if a no-tort automobile accident plan can be designed and delivered by private industry, then all that remains is an additional insurance dimension that would deal with the non-work, non-automobile injury. All accidents could then be covered.

The notion of a universal accident compensation scheme is not an unfamiliar one. New Zealand has had such a system since 1974 and by all reports it continues to operate efficiently, expeditiously and fairly. We have included a summary of the New Zealand system in Appendix 15 to provide readers with a better sense of what universal accident compensation would entail. However, here again, it is important to stress that unlike New Zealand, the Ontario compensation scheme would be designed and delivered by the private insurance industry.

(3) No-Tort Compensation For All Disability
This is really the logical extension of injury compensation: the extension to include

not just "accidental" injuries but indeed all disability — accidental injury, sickness and disease. The literature has demonstrated that there is no principled basis upon which to differentiate accidental injury from congenital defects or disease-related disability.

There would certainly be considerable advantage to a comprehensive approach to the needs of those disabled by accident and disease. As set out in Appendix 16, the uneven, patchwork nature of the present system of disability benefits in Ontario is particularly disturbing. For some time now, officials of the federal and provincial governments have had ongoing discussions about the possibility of a comprehensive disability scheme. Phase I of the study was completed in 1983 and the First Report submitted to the Ministers of Social Services in September 1983. It outlined the serious problems with Canada's disability income protection system and possible options for reform. In the second phase of the study, the Task Force was asked to develop and cost specific models. The draft Second Report was completed in November 1985 and is now under consideration.

For all practical purposes, however, although a comprehensive disability program was endorsed by the recent Macdonald Commission, it appears that universal disability may have to await a much wealthier economic base for its implementation and also a complicated process of rationalization between federal and provincial authorities and private insurers of the vast array of no-tort compensation schemes described earlier. In many ways then, universal disability compensation, although logically compelling, is realistically unattainable in the short-to-medium term.

The Task Force therefore recommends that:

B.28 In the short term, a new accident compensation scheme should be implemented by the private insurance industry at least for automobile accident injury. (This proposal is developed in more detail in Part C.)

B.29 Ideally and as a medium-term objective, government should begin to work with the private insurance industry to design a universal accident compensation plan that would include compensation for all accidental injuries.

B.30 Eventually and in the longer term, federal and provincial governments should begin planning the co-ordination and rationalization of all existing first-party no-tort compensation schemes into a universal disability compensation program.

The Task Force recognizes that these recommendations will raise many questions about design and content. There will also be some opposition and objection in principle. However, most of the objections to no-tort compensation tend to disappear with explanation and education. Many of the questions have already been answered in the literature.

The Task Force has not examined every detail in the design or delivery of a no-tort accident compensation system but it is confident that these details can be worked out through good-faith effort and an open-minded attitude. The basic thrust of our reform proposal is this: an important solution to the liability insurance crisis is in the development of a no-tort system of accident compensation.

NOTES — PART B

[1] Note that the farm mutuals have continued to provide both environmental impairment and "sudden and accidental" pollution coverage to agricultural producers at reasonable cost.

[2] Note that the Senate Committee voted to approve an expansion of the Risk Retention Act, 1981 to allow the formation of groups for self-insuring any type of commercial liability, not simply product liability.

[3] See Appendix 2.

[4] Referring to the decisions of the Supreme Court of Canada in *Andrews v. Grand & Toy*, *Arnold v. Teno*, and *Thornton v. Prince George*.

[5] See paper prepared for the Task Force by Philip Osborne and research cited therein.

[6] Osborne Study.
[7] *Ontario Lawyers Weekly* (February 21, 1986).

[8] *Ferguson v. Hamilton Civic Hospital et. al.* (1983) 40 O.R. 2d. 577.

[9] *Ferguson v. Hamilton Civil Hospital et. al.*, (1985) 50 O.R. 2d. 754 at 755 (Ont. C.A.)

[10] Belobaba, *Products Liability and Personal Injury Compensation in Canada: Towards Integration and Rationalization* (1983).

[11] Further support and documentation for these findings are provided in the Belobaba study.

[12] Feldthusen and McNair, "General Damages in Personal Injury Suits: The Supreme Court Trilogy", (1979), 28 U. of Toronto, L.J. 381.

[13] O'Connell, *The Lawsuit Lottery: Only the Lawyers Win* (1979).

[14] Belobaba study and references cited therein.
[15] Sellers study, attached in Appendix 17.

PART C

OTHER INSURANCE ISSUES

PART C

OTHER INSURANCE ISSUES

I AUTOMOBILE INSURANCE

Introduction

The Task Force has set out in Part B its serious concerns with the equity and efficiency of the personal injury compensation system, and its conclusion that the modern-day problem of injury compensation should be dealt with more efficiently, more expeditiously and more fairly. It was also proposed that, at the present time, the first step towards such a system should take place in respect of automobile-related personal injury accidents. This part will elaborate on this proposal and other related recommendations.

One particular empirical observation is important at this point. There are signs of significant changes in the bodily injury component of the automobile insurance system, which give rise to serious concerns about its continued acceptability to the public and its affordability in the future if present trends are left unchecked. As indicated in the 1985 *Automobile Insurance Experience* (Green Book), the frequency of bodily injury claims per insured car has increased over the last five years (1981-1985), and the average cost of bodily injury claims per insured car has steadily increased by an annual average of 14.8% over the same period, representing a real increase of 8.1% (after inflation). The increase in costs appears to be concentrated in the smaller claims (less than $50,000) since claims over $50,000 have increased by an annual average of only 6.2%. In the Task Force's view, this steady upward drift must be addressed now. It reflects dissatisfaction with the accident benefit program, which is contributing to increased use of the expensive tort/litigation system. The cost of the system is increasing, a trend that may soon press against the limits of affordability and acceptability.

The discussion is arranged as follows. First, a brief description of the evolution of the automobile insurance system in Ontario is set out. Second, the proposals for fundamental change in the personal injury compensation system are put forward. Finally, the need to change the rate structure and rate classification will be discussed, as well as the possibility of some form of systematic rate monitoring and surveillance, and various improvements to the marketing of the compulsory insurance product.

Evolution of the System of Automobile Insurance in Ontario

In order to describe the evolution of the system of automobile insurance in Ontario, it would be most useful to focus on the Standard Automobile Policy. This will facilitate an understanding of the extent of coverage currently available and the interface between compulsory and non-compulsory automobile insurance.

Section 201 of the Insurance Act provides that insurers shall use a uniform form of application, policy, endorsement or renewal certificate, as approved by the Superintendent of Insurance. The mandatory standard owner's form contains three broad sections. Each of these is discussed in turn.

Section A deals with third-party liability and provides for compensation to be paid to third parties. More specifically, it stipulates that the insured shall be indemnified against liability imposed by law for loss or damages arising from the ownership, use or operation of the automobile, and resulting from bodily injury to or the death of any person, or damage to property. It should be noted that the indemnity applies not only to the insured but also to every other person who, with his or her consent, personally drives the automobile.

This coverage was made compulsory in Ontario in March 1980, following the recommendations of the Select Committee on Company Law and the enactment of the Compulsory Automobile Insurance Act. As of March 1, 1981, the minimum compulsory coverage was increased from $100,000 to the current level of $200,000. It should be emphasized that this is the lowest limit that may be purchased, and consumers are urged to buy considerably higher amounts.

Section B of the Standard Automobile Policy deals with Accident Benefits Coverage. In fact, it is in substance a separate policy, being independently set out in Schedule E of the Insurance Act, and should therefore be read as an independent document. The benefits are payable to the insured regardless of fault. The provisions were implemented on an optional basis in 1969, but were made mandatory in 1972 in all automobile insurance policies issued in Ontario that contained third-party liability coverage. The coverage was then enriched in 1978 to the current level of benefits noted in the following table.

ACCIDENT BENEFITS
(SECTION B, STANDARD AUTOMOBILE POLICY)

MEDICAL PAYMENTS	$25,000 per person including rehabilitation, excluding Government Health Insurance Plans. Time limit: 4 years.
FUNERAL EXPENSE BENEFITS	$1,000 maximum.
DISABILITY INCOME BENEFITS	80% of wages, maximum of $140.00 weekly, 104 weeks temporary. Lifetime total and permanent first day cover. Non-contributory first 14 days. Unpaid housekeeper, $70.00 per week, maximum 12 weeks.
DEATH BENEFITS	Death within 2 years after accident. Head of household, no age limits, $10,000. Plus $1,000, each dependant beyond first, no limit. Spouse, no age limit, $10,000. Dependent child, $2,000.

It should be noted that all provinces have now opted for some form of add-on no-fault bodily injury compensation, with the notable exception of Quebec, which has opted for a no-tort system for personal injury compensation. Chart 1 sets out the comparative compensation schemes.

Note that Section B now includes mandatory uninsured motorist coverage. This provides coverage to the policyholder in the event that he or she is injured through the fault of an uninsured motorist.

Finally, reference should be made to Section C of the Standard Automobile Policy, which provides for four different sub-classes of coverage for loss of or damage to the insured automobile, from which the insured can make his/her selection:

Subsection 1	**All Perils** — The insurer agrees to indemnify the insured against direct and accidental loss of or damage to the automobile, including its equipment, from all perils, as defined.
Subsection 2	**Collision or Upset** — The insurer's obligation is limited to loss or damage caused by collision with another object or by upset.
Subsection 3	**Comprehensive** — The insurer's obligation is limited to damage from perils other than by collision with another object or by upset.
Subsection 4	**Specified Perils** — The insurer's obligation is limited to damage caused by fire, lightning, theft or attempt thereat, windstorm, earthquake, hail, explosion, riot or civil commotion, falling or forced landing of aircraft or of parts thereof, rising water, or the stranding, sinking, burning, derailment or collision of any conveyance in or upon which the automobile is being transported on land or water.

Each occurrence, with minor exceptions, shall give rise to a separate claim, and the insurer's liability is limited to the amount of loss in excess of the selected deductible amount.

In any discussion of the evolution of the autombile insurance system in Ontario, mention must be made of a particularly important component of the current Ontario structure relating to compulsory automobile insurance — the Facility Association. With the advent of compulsory automobile insurance in 1980, it was imperative to ensure that all drivers had access to the necessary insurance. Rather than adopt the "take all comers" principle advocated by the Select Committee, whereby all insurers would have to accept all applicants, the Facility Association was created as a successor to the Facility. It is a non-profit organization comprising all licensed automobile insurers in Ontario who share the losses of the organization.

The principal purpose of the Association is to guarantee market availability upon payment of the premium to any licensed driver in Ontario who cannot obtain insurance through the ordinary market system. Insurance is placed through some eleven servicing carriers who are licensed insurers. The rates charged for business placed are uniform, and reviewed by the Superintendent. The coverages are such as to ensure the availability of automobile insurance as required by law. (Note that in December 1985, under special authority, the Association undertook to permit limits for third-party liability of up to $5 million (U.S.) inclusive, to meet the special filing requirements of the United States Inter-State Commerce Commission with respect to Canadian Carriers.)

The primary users of the Facility Association have been high-risk drivers, including young male drivers. As noted above, during the recent hard market, it has become clear to the Task Force that an unusual number of drivers have been classed as unacceptable high-risk drivers by insurers and have been directed to the Facility Association. This is a disturbing trend, and will be addressed in greater detail in the discussion of the proposed changes to the rate structure, possible forms of rate regulation, and improvements to the marketing of automobile insurance generally and the compulsory component in particular.

The foregoing discussion has sketched the evolution of the system of automobile insurance in Ontario. The next section will deal with proposals for fundamental changes to the personal injury compensation system.

Options for Reform of the Automobile-Related Personal Injury Compensation System in Ontario

As noted earlier, the Task Force is seriously concerned with the longer-term implication of the steady upward drift in average settlements and awards for bodily injury for the equity, efficiency and affordability of the present system.

The foregoing concerns have led the Task Force to question the efficacy of the current system of accident benefits. When accident benefits were first introduced, it was expected that

Canadian Automobile Insurance Plans (as of July 1, 1985)

Nfld.	Que.	Ont./N.S./N.B./P.E.I.	Man.	Sask.	Alta./Yukon	B.C.	N.W.T.
Third Party Liability (Bodily Injury and Property Damage) Compulsory in all provinces							
Minimum $200,000.	Minimum $50,000. No Exposure to Bodily Injury within Quebec	Ont. - Min. $200,000 N.S. - Min. $200,000 N.B. - Min. $200,000 } Jan 1 1986 P.E.I. - Min. $200,000 }	Minimum $200,000	Minimum $200,000	Alta. Min. $200,000 (Jan. 1, 1986) Yukon Min. $200,000	Minimum $200,000.	Minimum $50,000.
Medical Payments							
$2000. per person excluding amounts under Government Medical & Hospital Plans Time Limit: 2 years	No time or amount limit Includes rehabilitation	$25,000 per person including rehabilitation excluding Government Health Insurance Plans Time Limit 4 years	$20,000 per person excluding Compulsory Health Insurance Scheme	$10,000 per person discretionary to meet expenses	$5000 per person including rehabilitation Excluding amounts under Government Medical & Hospital Plans	$200,000 per person subject to third party limit; includes rehabilitation, excludes Government Medical & Hospital Plan	$2000 per person excluding amounts under Government Medical & Hospital Plans
Funeral Expense Benefits							
$800. maximum	$2477.42 maximum	$1000 maximum	$1500 maximum	None	$1000 maximum	$1000 maximum	$500 maximum
Disability Income Benefits							
$35.00 per week 104 weeks temporary + 104 weeks permanent 7 day deductible Contributory Housewife $12.50 per week Max. 12 weeks	Min. $145.31 per week or 90% of net wages Max. Income Gross $33,000 per year Temporary - 5 years Permanent - lifetime 7 day deductible Non-contributory	80% of Wages Max $140.00 weekly 104 weeks temporary + Lifetime total & permanent Ont. first day cover Non contributory first 14 days N.S. & P.E.I. 7 day franchise Contributory Unpaid housekeeper $70.00 per week Max 12 weeks	$150.00 per week or 70% of wages Max $300.00 weekly 104 weeks partial @ $60.00 7 day deductible Contributory Housewife Lifetime Total $150.00 weekly Partial $80.00 weekly Max 20 weeks	$150.00 per week Lifetime Total 104 weeks partial @ $75.00 7 day deductible Contributory Housewife $150.00 weekly Total $75.00 weekly Partial Max 104 weeks	80% Gross Wages Max $150.00 weekly Yukon Min $40.00 weekly 104 weeks temporary or total 7 day deductible Contributory Housewife $75.00 per week Max 26 weeks	75% Gross Wages Max. $100.00 weekly 104 weeks temporary + Lifetime total & permanent 7 day deductible Contributory Housewife $100.00 per week As above	Employed Person 80% Gross Wages Max $50.00 weekly Min. $40.00 weekly 104 weeks temporary or total 7 day deductible Contributory Housewife $50.00 per week Max. 26 weeks
Death Benefits							
Death within 3 months after accident Married Male Age Limits: 10-59 - $5000. 60-69 - 3000. 70 + - 2000. Plus $1000. each dependent child No limit Married Female Age Limit: 10-59 - $2500. 60-69 - 1500. 70 + - 1000. Unmarried Person with living parents Scale by age. Maximum $2500.	Death anytime after accident Pension to dependent survivors based on Disability Income Benefits of Deceased Min $145.31 Without dependent $7432.26 or $3716.13	Death within 2 years after accident Head of Household Age Limits None $10,000 Plus $1000. each dependent beyond first No limit Spouse No age limit $10,000 Dependent Child $2000	Death anytime after accident Head of Household Age Limits None $10,000 Plus $2000 each secondary dependent Limit $10,000 Spouse No age limit $10,000 Dependent Child Maximum $2000	Death within 2 years after accident Head of Household Age Limits None Plus $1500 each secondary dependent Dependent Child. $1500	Death anytime after accident Head of Household $5000 plus $1000 for each dependent beyond first + 1% of Total Principal Sum for 104 weeks No Limit Spouse $5000 Dependent Child Scale by age Maximum $1500	Death anytime after accident Head of Household $5000 + $100.00 Weekly for 104 weeks Plus $1000. + $25.00 weekly for 104 weeks for each dependent beyond first No limit Spouse $2500 Dependent Child Scale by age Maximum $1500	Death anytime after accident $5000. + 1% per week for 104 weeks Head of Household Age Limits 10-64 $5000 65-69 3000 70 + 2000 Plus 20% of Principal Sum for each dependent beyond first No limit Spouse Age Limit 10-64 $2500 65-69 1500 70 + 1000 Dependent Child Scale by age Maximum $1500.
Dismemberment Benefits							
Schedule based on 50% - 100% of Principal Sum	Scheduled up to $36,327.06	Not included. Becomes part of other recovery	Scheduled Benefit* Maximum $20,000 Deducted from death benefits	Scheduled Benefits Maximum $10,000	Not included. Becomes part of other recovery	Not included. Becomes part of other recovery	Not included. Becomes part of other recovery
Administration							
Private Insurers	Government - bodily injury Private Insurers - property damage	Private Insurers	Compulsory Insurance Government Monopoly Optional and Excess Government and Private Insurers compete		Private Insurers	Same as Manitoba and Saskatchewan.	Private Insurers

- Alberta, Ontario and Manitoba residents involved in accidents in Quebec receive from their own insurer the equivalent to the benefits available to Quebec residents from the Régie.
- Accident Benefits Coverage is compulsory except in Newfoundland.
- Collision insurance is optional except in Manitoba ($200 deductible) and Saskatchewan ($500 deductible).

(**Insurance Bureau of Canada,** *Facts of the General Insurance Industry in Canada,* **13TH EDITION**) with ready access to expeditious, up-front no-fault payments, accident victims would find it less necessary to resort to the expensive tort system. This clearly has not happened. Instead, the level of accident benefits has stagnated since 1978 and deteriorated substantially in real terms so as to provide very little incentive to innocent accident victims *not* to pursue their actions through the tort system. Indeed, the income replacement component has now fallen behind the minimum wage.

Special note should also be made of severe constraints often imposed on accident victims by the $25,000 cap on first-party medical payments, including rehabilitation. In this connection, the Task Force notes that a number of groups and individuals have made thoughtful submissions stressing the value of rehabilitation services not only in maximizing the recovery and well-being of accident victims, but also in minimizing expensive outlays for other types of medical expenses.

The Task Force has closely examined a number of options for reform to the personal injury compensation system with a view to improving both its efficiency and equity. Some of the experiences in other jurisdictions are set out in detail in Appendices 12, 13, 14 and 15. It is important to emphasize at this point that the Task Force will only address options to reform the bodily injury component of the automobile insurance system, and it is not proposing to make any alterations in respect of the property damage component at this time.

Based on this examination the Task Force has concluded that an essential element in the reform of the bodily injury component of the automobile insurance system is first-party insurance coverage. The foundation of any reform must be compensation for losses and costs due to bodily injury that meets the standards of the majority of the population fairly, efficiently, promptly, economically, predictably and with as little litigation as possible. The Task Force is convinced that the new system can be delivered privately by the general insurance industry subject to minimum guidance from government. The Task Force therefore recommends that:

C.1 The Government of Ontario should work with the insurance industry to devise the framework for the private delivery of the new system of personal injury compensation recommended herein. Particular emphasis should be placed on ensuring the provision by the industry of adequate layers of first-party insurance coverage above the minimum mandatory compensation levels, as well as ensuring access to adequate rehabilitation services. In addition, the industry, with the assistance of the Government, should establish a pooling mechanism such as a catastrophic claims fund to ensure that all insurers, regardless of size, are in a position to meet their obligations to provide first-party coverage in respect of victims of catastrophic injury. The Facility Association can perhaps provide the necessary mechanism. Finally, the Government must ensure that the industry establishes adequate dispute resolution mechanisms, whether by way of expeditious arbitration or otherwise.

C.2 The Government of Ontario should then introduce a mandatory system of auto insurance for personal injury compensation whereby all insureds purchase a basic minimum level of insurance including coverage for loss of income, costs of care, and unlimited rehabilitation and medical expenses. The minimum level for loss of income should be set at a level such as to cover a clear majority of the population of Ontario, and should be subject to the appropriate cost-of-living indexation formula, and to an annual review by a committee of the Legislature. Where considered appropriate, insureds could purchase additional layers of income replacement coverage on an individual or group basis.

In establishing the appropriate basic mandatory compensation program, it would be desirable to establish a level such that a majority of the population in Ontario could rely on the automatic coverage, and would not have to purchase additional layers of insurance for income replacement related to bodily injury from auto accidents. In this connection, further study must be made of the income distribution in Ontario, but based on some preliminary research, the Task Force suggests that a mandatory first-party insurance coverage based on an income replacement compensation of net income up to the equivalent of a gross maximum weekly wage or salary of $600 (approximately $31,000 per annum) might be appropriate. Additional layers of income replacement could be available on an optional basis within first-party coverage in automobile insurance contracts. Other categories must be established such as to provide appropriate minimum levels of compensation to such persons as homemakers, children and students. Lifetime benefits would be provided, and would be adjusted to the degree of impairment of earning capacity, as appropriate.

One particular issue that must be addressed in connection with the provision of the costs of care of injured persons, particularly those who are seriously and permanently injured, is how to ensure that the design, administration and scale of benefits of the system are sufficiently flexible to accommodate important social choices, such as those favouring home care over institutionalized care. The Task Force is of the view that this should be given close attention.

With respect to the other compensation components, the Task Force recommends unlimited rehabilitation and medical benefits. The Task Force has been much impressed with the value and cost-effectiveness of rehabilitation. Moreover, drawing on the experience in Michigan in particular, as described below, unlimited benefits can be handled by the private industry, in conjunction with a catastrophic claims fund to spread the risk. A 1982 study in Michigan perhaps demonstrates this value most succinctly with the following observation:

> Recent estimates have shown that for every dollar spent on rehabilitation, nine dollars are returned through increased productivity and that for every rehabilitated spinal cord injury, $60,000 in future medical and nursing home costs are saved. However, a successful rehabilitation is generally possible only if an individual gets appropriate treatment as soon after the accident as possible. Placing a ceiling on Personal Injury Protection payments will serve to introduce uncertainty for the injured individual on whether or not he or she can afford rehabilitation treatments. This uncertainty inevitably causes delay and markedly reduces the possibility of successful rehabilitation.

With respect to the private delivery of any new system of personal injury compensation, the Task Force is convinced that the private general insurance industry is ready, willing, and able to provide the necessary first-party coverage — both the mandatory minimum component and the subsequent layers of coverage — tailored to an individual's personal income circumstances. In this connection, it is interesting to note that in Quebec, where a no-tort compensation system is already in place, the private insurers provide supplementary disability insurance on an individual or group basis beyond the minimum coverage provided by La Régie de l'assurance automobiles. In addition, they stand ready to supply the minimum mandatory coverage as required by the Government, should the Government decide to spin off this function from La Régie.

Certain areas would of course require special attention. For example, the Government must be vigilant and ensure that adequate rehabilitation services are provided by the private sector. In this connection, the Task Force has been made aware of the already substantial private-sector involvement in the provision of rehabilitation services at the present time.

Insurers must also be required to establish expeditious and fair internal arbitration procedures to deal with unsatisfied insureds, perhaps similar to the procedures set out in Section 125 of the *Insurance Act* in respect of fire insurance. (See also Section 207(8) in respect of disagreement over appraisals in respect of automobile accidents.) Indeed, it is interesting to note that as early as 1979, the Select Committee recommended the extension of this access to arbitration to all kinds of property and casualty insurance. Many others have recommended greater use of the Arbitrators' Institute of Canada Inc. In any event, there is certainly no compelling reason at this stage for a publicly established administrative review system such as the Workers' Compensation Board and the recently created Workers' Compensation Appeal Board. Nonetheless, the situation must be monitored closely.

In addition, consideration must be given to the integration of the private insurance benefits with the panoply of available public benefits. For example, at present, under a special agreement with the Ontario Health Insurance Plan, most but not all insurers have arranged to compensate OHIP according to a pre-established formula, in return for which OHIP has given up its right of subrogation. This, however, applies only to motor vehicle accidents where the wrongdoer is insured. If the wrongdoer is uninsured and a claim is asserted against the victim and insurer pursuant to the uninsured motorist cover, OHIP still has the right to assert its subrogated interest. Certainly, new arrangements with OHIP must be worked out as part of any new compensation scheme for victims of automobile accidents.

More generally, however, a more rational approach to resolving the variety of subrogated interests is required in order to enhance the efficiency and equity of the new compensation system. This will involve an examination, among other things, of the Vocational Rehabilitation Program operated by Ontario's Ministry of Community and Social Services to assist in modifications to the home and workplace; prosthetic devices and retraining; the Residential Rehabilitation Assistance Program operated by Canada Mortgage and Housing Corporation for home modifications; the assistive devices program of the Ministry of Health of Ontario, which pays approximately 75% of the assistive devices for persons 21 years of age or younger; Unemployment Insurance; and the Canada Pension Plan. The subrogated interests of the Vocational Rehabilitation Program as well as the CHAMP Program sponsored by the War Amputations of Canada must also be considered.

Finally, in concluding this discussion of the private delivery of the new compensation system, mention must be made of the need to assist the industry in forming a pool to spread the risks of catastrophic claims. This is an essential mechanism in order to ensure that the obligation to provide unlimited rehabilitation and medical benefits does not impose an excessive and unfair burden on small insurance companies that happen to have insured persons who suffer catastrophic injuries.

Such an industry association has been successfully formed in the state of Michigan. All automobile insurers are required to be members. The association is directed to indemnify insurers for all losses that are expected to exceed $250,000 and to "calculate and charge to members of the association a total premium sufficient to cover the expected losses and expenses of the association", according to a statutory formula. The structure and operation of the Association are set out in detail in Appendix 14. Conceivably, Ontario could draw on this experience and that of the Facility Association to create the necessary mechanism.

Consideration must also be given to the so-called "pain and suffering" or non-economic component of damages. As has been emphasized in Part B above, there is already a firm cap on such damages imposed by the Supreme Court of Canada — $100,000 in 1978 dollars, now approximately $184,000. It must be noted that a component for pain and suffering could be built into the basic compensation system, if considered desirable by the government, and then purchased as part of the additional layers of protection. The point should be made, however, that most commentators in the personal injury compensation literature discouraged the addition of any non-pecuniary item to an injury compensation plan. The matter remains controversial and will undoubtedly have to be resolved in due course, as the no-tort insurance plan takes shape.

The Task Force is convinced that such a new system of personal injury compensation would meet the standards set out above. It should go a long way toward reducing the trend toward litigiousness — toward no-tort or limited use of the tort system for compensation for bodily injury from auto accidents. But in view of the fundamental distortions, inefficiencies, inequities and lottery nature of unrestrained use of the tort system in this field, the Government should consider limitations on its use. The Chairman's preference is for a no-tort system in this field as set out in recommendation C.3, but he recognizes that the threshold limitation set out in recommendation C.4 may be more acceptable at this time, even though he considers that it would be inequitable. The Task Force therefore recommends that:

C.3 The Government of Ontario should consider elimination of resort to the tort/litigation system with respect to personal injury compensation from automobile accidents; or

C.4 The Government of Ontario should consider substantially limiting resort to the tort/litigation system with respect to personal injury compensation from automobile accidents, by way of a threshold.

The basic case for substitution of a compensation and deterrence system for the existing tort/litigation system has been set out in Part B of this Report. More efficient and equitable systems are available. A compensation system such as the one described above, together with the deterrence and incentive system discussed below, is likely to be a more appropriate framework within which to deal with bodily injury from auto accidents for the decades ahead.

It is important to recognize the accomplishments of the tort/litigation system as it has evolved in Canada and in Ontario during the last few decades. It has played a leading role, often in spite of rather than with the help of governments, in adapting the standards and ranges of application of compensation for bodily injury to the needs and capabilities of society. It has interpreted the changes in social values and applied them to individual cases. It has reflected society's changing preferences for home over institutional care for some severely and permanently injured persons. It has interpreted changes in standards of living in adjudicating income replacement and supplementation. It has established what society appears to consider reasonable standards for non-economic damages, such as pain and suffering. It has promoted high standards of professional conduct.

Why then consider eliminating or limiting resort to the tort/litigation system for bodily injury arising from auto accidents? First, there are signs that it is deteriorating; that it has had to try to accomplish too many objectives with too few instruments. Second, there are signs of increased litigiousness in society, particularly regarding bodily injury from auto accidents, which may not be adequately discouraged by the new system of personal injury compensation recommended above. Third, the system is not now able to deal with the accident injury compensation in a principled, consistent way, for reasons set out in Part B of this Report.

Having said this, however, if the decision is nonetheless made to preserve the tort/litigation fragment for use in special circumstances, the difficulty remains in designing the appropriate "threshold". Should it be a "monetary" threshold that would permit litigation when actual or anticipated income losses exceed those offered under the basic insurance plan? Or should it be a "verbal" threshold that would attempt to reserve access to tort for those cases where serious injury has resulted in "loss of a bodily function or permanent disfigurement"? Both of these approaches present further difficulty. If the threshold is a monetary one geared to excess-income claims, does it make sense to retain the tort vehicle for these situations? The only persons who would resort to lawsuits for these excess economic claims would be those who had chosen not to purchase additional layers of coverage. If this is so, would there not then be cross-subsidization of the higher-income earners? And if a verbal threshold is employed so that non-pecuniary recovery can be obtained for the permanently disabling injury, does it make sense to preserve tort litigation, given the "cap" on pain and suffering, and given that in any event this item of intangible injury could be made a component of the basic first-party no-tort insurance package?

The Task Force raises these concerns because it recognizes that a number of American states have opted for a "modified" tort/no-tort system for automobile injury compensation. These states have done so, however, in the context of an American court system that presently allows an unlimited recovery for intangible losses such as pain and suffering. This is not the case in Canada. Thus, any discussion in the Ontario context of the value of "modified" tort and the viability of a "threshold" should understand this difference in our law, and should address the questions raised above.

The Task Force is convinced that incentives for good behaviour and penalties or deterrents for bad behaviour should be a part of the auto insurance system. These should involve the implementation of a bonus-malus system, safe driving campaigns, better safety standards and equipment, and stricter Criminal Code sanctions, and also changes to an integrated data base relating to drivers' claims histories and conviction records, and to permit insurers to have access to this information on an on-line basis. Accordingly, the Task Force recommends that:

C.5 In conjunction with the introduction of a new system of personal injury compensation, the Government of Ontario should work with the insurance industry on an urgent basis to enhance the deterrent to hazardous driving, and to implement an effective bonus-malus system for setting automobile premium rates. At the same time, the Attorneys-General of both Ontario and Canada should be strongly encouraged to continue their efforts to ensure more appropriate criminal penalties in respect of unsafe driving.

C.6 To ensure the effectiveness of the bonus-malus system, the Government of Ontario should work with the industry to devise a plan to create an integrated data base to provide drivers' claims histories, conviction records and driving experience, and explore how to make this essential information available on an on-line basis.

With respect to the bonus-malus system, it would be useful to first set out some background to the bonus-malus systems now in existence, with particular reference to the claims-rated system so successfully implemented by the Insurance Corporation of British Columbia. It will then be possible to put forward some recommendations for appropriate reform in Ontario.

Since the 1960s, a number of European countries have developed, as part of the automobile rating system, a bonus-malus system designed to reflect the claims recorded against a vehicle. The *bonus*, or merit factor, is a premium discount the insured is entitled to if no claim is made in the policy period. The *malus*, or demerit factor, is a premium increase charged as a result of a claim made during that period.

The key elements of the system are illustrated by examining the table used in Switzerland, as follows:

Bonus (Discount)										**Entry Point**												(Surcharge) **Malus**
Step	0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21
%	50	50	60	60	70	70	80	80	100	100	120	120	140	140	170	170	200	200	230	230	270	270

The system considers claims against the policy, regardless of the driver of the vehicle. A new owner enters the system at Step 9 (100%) and moves down the scale (bonus) for each subsequent claims-free year, with a premium reduction at two-year intervals. For each claim reported, the insured regresses (malus) by three steps and the renewal will be subject to the appropriate differential, e.g., one claim, 140%, two claims, 170%. The increments on the scale are arbitrarily established by the regulatory authorities and not actuarially cost-justified.

There are some who doubt that a similar system could be adapted to the Canadian market as it exists today. First of all, there has to be complete co-operation on the part of insurers to voluntarily exchange claims information, so as to prevent an insured person from obtaining a more favourable position on the scale by changing companies and withholding historic information. In Switzerland there are only twenty-six companies, with four of them writing 60% of the business. In Ontario there are over a hundred companies competing for the available business, with no one predominant company in the market. The Task Force believes, however, that both these objections can be overcome through the appropriate design of the Ontario system as set out herein.

The ICBC claims-rated scale provides the most useful model for Ontario and should be set out in some detail. As of January 1, 1983, premiums for ICBC Autoplan coverages were charged according to a claims-rated scale of discounts and surcharges. (Note that in British Columbia, the insurance renewal is payable at the same time as the motor vehicle licence renewal, and the decal and insurance certificate are both issued by the ICBC Autoplan Agent or Motor Licence Office.)

The features of the claims-rated scale are as follows:

- Each Third-Party Liability and Collision claim for which a payment is made moves the vehicle owner's premium *three steps up* the scale. There is no limit to the number of steps, or levels, above the base rate.

- Each claim-free year moves the vehicle owner's premium *one step down* the scale until it reaches the fourth and lowest level of discount.

- As an incentive for improvement, where a premium is still above the base rate after three consecutive claim-free years, it will be returned to the base rate.

- A "forgiveness" feature has been introduced, which means that where liability in a claim paid in 1986 is 25% or less, the premium will not be increased.

- The position on the claims-rated scale is not affected by claims for No-Fault Accident Benefits, hit-and-run, windshield, theft, or vandalism claims, or any other loss paid under Comprehensive, Specified Perils, Underinsured Motorist Protection, Loss of Use coverage, or claims for loss under $10.

- Responsibility for the use of a vehicle remains with the owner, whether it is driven by the owner or by another person with the owner's permission.

- A driver or vehicle owner coming from outside the province is required to verify eligibility for a discount or enter at the base rate. Verification requires the insured to make a declaration and to present documents from prior insurers showing claim status for the previous four years.

In investigating the system of automobile insurance in British Columbia, the Task Force was particularly impressed with the effectiveness and efficiency of the claims-rated scale. There appears to be no reason why a similar system could not be equally successfully implemented in Ontario.

The Task Force notes, however, that the success of the ICBC system is due in large measure to the comprehensive data base to which all brokers have access; the fact that insurance renewal is linked to motor vehicle licence renewal; and that the decal and insurance certificate are both issued by the ICBC Autoplan Agent or Motor Licence Office. In the Task Force's view, it is entirely feasible to introduce a similar link between vehicle registration and automobile insurance in Ontario at this time, given that auto licensing is now changed to associating licence plates with owners rather than vehicles.

Moreover, it will provide the key element in the development of an integrated data base — something that is critical as more and more emphasis is being placed on driving record and experience for premium rating criteria. In this connection, the Task Force is well aware of the less-than-adequate state of the automobile industry data bases and access to claims information and conviction records. For example, the Task Force has been informed that automobile insurers face delays of up to six weeks in obtaining motor vehicle abstracts from the Ministry of Transportation and Communications. This is totally unacceptable.

Fortunately, some steps have been taken toward the eventual implementation of a 24-hour "tape-to-tape" exchange between insurers and MTC. In late fall of 1985, a successful pilot project was undertaken by Royal Insurance Canada and the Ministry. A more extensive implementation of this project has not been forthcoming, perhaps pending clarification of the insurer's right to the necessary information under the proposed "Freedom of Information and Individual Privacy Act", although individuals do consent to the insurer's access to this information when they complete their application for insurance.

In addition, several significant developments in respect of industry data bases were announced in March 1986. In particular, the Insurers' Advisory Organization has received a couple of proposals to develop and implement an automobile-claims-tracking data base and reporting service that would track automobile insurance claims by drivers' licence number. Subscribers to the system could access the system, which would report the claims history of the driver. Insurers would be able to obtain this information quickly, without searching loss histories with other companies, and could readily identify false or misleading applications. It is understood that the IAO has approved the proposal and the concept in principle, and that implementation appears to be contingent upon further investigations of the cost.

In addition to a bonus-malus system and the related data base proposals discussed above, much more emphasis must be placed on initiatives such as safe driving campaigns, driver education courses, and the use of safety equipment such as seat belts, special children's car seats, and so forth. In this connection, the experience in British Columbia is again encouraging. The ICBC has put a great deal of effort into a "buckle-up" campaign, and nearly 75% of British Columbia drivers use seat belts compared with an average of 63% for all eight Canadian provinces with seat belt legislation. Statistics now prove that the use of seat belts has reduced traffic fatalities by at least 60%. And for every 1% increase in seat belt use across British Columbia, deaths and injuries are significantly reduced, resulting in a community cost savings of $1.35 million per year.

Finally, the Task Force welcomes and encourages the recent efforts of both the provincial and federal Attorneys-General in strengthening the Criminal Code sanctions against dangerous driving. This already has had and will continue to have a beneficial impact on the safety of our roads and reduce the probability of automobile accidents.

Automobile Rate Structure

The primary issue that has arisen in respect of the automobile rate structure in Ontario is the question of classification by age, sex and marital status. This will therefore be addressed in reasonable detail. In addition, the Task Force has been made aware of many other instances of contentious rating practices, such as that of linking premiums for close relatives even if they drive different cars, and that of very high premiums charged to parents of children under 22 years of age who may drive the family car. The rationale for such practices seems to be the fact that insurance companies provide coverage to anyone driving the car with the owner's permission. Therefore, insurers understandably want to ensure that all potential drivers have good driving records. Note also that, since the Highway Traffic Act makes the owner liable for the negligence of the authorized drivers of the vehicle, without third-party insurance every owner would be at risk.

The Task Force recognizes the serious concerns that such rating practices have elicited on the part of the public, and urges the Superintendent of Insurance to work with the insurance industry in seeking out the appropriate means to address the complaints. The root of many of the problems, however, lies with the questionable use of age, sex and marital status classifications, a subject to which the discussion will now be directed. The current classification system for automobile premiums has evolved in a complicated fashion. Currently there are no less than fourteen different classifications of drivers. Both insurers and actuaries insist, however, that this is entirely consistent with and justified by the evidence of the statistical probability that certain classes of drivers are more likely to be involved in an accident.

Discussions on whether or not to develop alternative rating criteria to eliminate those of age, sex and marital status have been ongoing for some time. The Select Committee on Company Law put forward its recommendation for the elimination of these criteria in 1978. Since that time, British Columbia, Saskatchewan, Manitoba and Quebec (at least in respect of bodily injury) have taken steps to eliminate the classifications.

On January 1, 1985, the Statistical Plan, prepared by the Insurance Bureau of Canada at the instruction of the provincial Superintendents of Insurance, was amended to begin the collection of certain alternate data. This Plan captures automobile insurance data for all Canadian jurisdictions other than those provinces with public automobile insurance systems. Because of the need to obtain the concurrence of all the provincial superintendents on the matter, it is clear that some passage of time may be required to implement this recommendation. Indeed, the industry argues that it may be 1990 before the industry has statistics that are sufficiently credible to formally delete age, sex and marital status criteria. However, it is highly likely that a variety of legal challenges will not countenance such a delay.

For example, the consensus of opinion appears to be that the use of the gender criterion by public bodies subject to the Charter infringes the Charter of Rights and Freedoms and is open to successful challenge. The use of the age criterion was successfully challenged under the Ontario Human Rights Code in the recent case of *Bates v. Zurich Insurance Company.* The case is presently under appeal.

Regardless of the legality of the particular criteria, it appears clear to the Task Force that age, sex and marital status have outlived their usefulness as surrogates for the degree of risk or hazard that persons impose on the system. Instead, the focus should be placed on driving records, driving experience and perhaps mileage as more logically supportable alternatives. In this connection, it is useful to note that both the Superintendent and the Facility Association are not opposed to replacing age, sex and marital status criteria as soon as adequate alternative criteria can be found.

The Facility Association anticipates major difficulties in considering alternative criteria such as driving experience because of the difficulty in obtaining information on accidents and convictions for 16- and 17-year-olds as a group, due to the *Young Offenders Act.* Yet the Facility Association could be required to lead the way in Ontario in dealing with this issue if, due to its being regulated by the Government, it is forced to comply with the Charter.

It should be noted parenthetically that, to its credit, the Facility Association does build in a small discount for young drivers that offsets the higher premium to some extent. More specifically, private passenger vehicle premiums include a 9% commission for male drivers aged 16 to 22, and an 11% commission for all other classes. Similarly, the IAO advises that its rates for classes 10, 11 and 12 (unmarried male, age 16 to 18; age 19 to 20; and age 21 to 22) — the three highest risks in their manual — include a lower level of expense loading. IAO rates for these classes only allow a 10% commission and they deduct 2% from company operating expenses. In a recent filing, the expense loading for these classes was 23.3%, compared to 27.5% - or about 15% less than all other classes. The Task Force has been informed that most insurers have adopted this procedure.

In light of the foregoing discussion, the Task Force recommends that:

C.7 The Superintendent of Insurance, together with his counterparts on the Canadian Council of Superintendents of Insurance, should take the necessary action to ensure that all automobile insurers in the various jurisdictions comply with the reporting requirements under the Statistical Plan as amended on January 1, 1985.

C.8 The Government of Ontario should encourage its provincial counterparts to support a uniform date between January 1, 1989, and September 1, 1989, for the implementation of the elimination of age, sex and marital status criteria. This should give the industry adequate time to collect and analyze data, and be ready to apply appropriate alternate criteria.

Rate Regulation

The Task Force has emphasized that the primary problem in the automobile insurance market is that of affordability as opposed to availability, and that fundamental change is required in respect of the bodily injury component of the insurance premium as distinct from the property damage component. Many of the recommendations in the preceding sections will, the Task Force believes, cumulatively promote the objective of a more cost-effective and equitable automobile insurance system leading to better service, lower premiums, or both. For example, the adoption of a no-tort system for bodily injury is demonstrably cost-effective. In addition, the eventual elimination of age, sex and marital status classifications and the adoption of an effective bonus-malus system will ensure that the burden of higher premiums is placed on the truly high-risk drivers.

The possibility of a broader government presence in rate-making must now be briefly addressed. This is dealt with in detail in Part D in the context of proposals for a more systematic evaluation, monitoring and surveillance of rates in all lines of general insurance, not simply automobile. This section will deal only with certain observations relating to compulsory automobile insurance. In this connection, the Task Force believes that stronger powers of rate regulation in respect of the *Compulsory Automobile Insurance Act* would be appropriate at this time. A little background to recommendations in this area would be useful.

The *Compulsory Autombile Insurance Act* gives the Superintendent the power to approve or disallow rates for the residual market that are not in accordance with statistical evidence, experience or other justifiable factors, by-laws and articles of the Facility Association. The Act defines the Facility Association and authorizes it to establish a plan of operation to include the compulsory third-party liability and accident benefits coverage as well as the non-compulsory coverage. Officials in the Office of the Superintendent have taken the position that they have the authority to approve all rates filed by the Facility Association, not only the rates for compulsory coverage, and in fact are acting on this basis. Their view is that the plan of operation must be changed to exclude non-compulsory coverage in order for them to confine their regulatory scope to compulsory coverage.

No similar authority for the Office of the Superintendent is contained in the *Insurance Act* since Sections 369-371 of the Act have not been proclaimed. Accordingly, for the segment of the compulsory automobile insurance that resides in the voluntary market, the Superintendent's role is limited to the monitoring of market conduct by responding to specific complaints, and the Office relies on competition as an effective regulator.

In the practical application of the Superintendent's powers to approve rates for the Facility Association, the approval process is slow as it requires public notice and a hearing, and the preparation reflects a shortage of casualty actuarial skills. The delays have a significant financial impact because the lower rates are used for an extended period of time which is now up to four months.

There appears to be confusion about the extent of the Superintendent's authority over the non-compulsory coverage offered by the Facility Association to the residual market. To address this, the Task Force recommends that:

C.9 The *Compulsory Automobile Insurance Act* should be amended to clarify and extend the Superintendent's regulatory power to the non-compulsory component of coverage in respect of both rate levels and classifications and surcharges used by the Facility Association.

More generally, the Task Force is also of the view that the public is not yet able, as it should be, to obtain the compulsory insurance product at the lowest possible cost. One change that might ensure the availability of at least compulsory insurance at the lowest cost would the establishment of a mandatory basic rating classification system as recommended by the Select Committee in 1978. This of course would have to be examined in conjunction with the above recommendations for elimination of age, sex and marital status classifications. To date, such a broad-based scheme has been strongly resisted.

The Task Force has concluded that the establishment of a mandatory basic classification system, at least with respect to compulsory automobile insurance, would be a valuable step to take at this time. It is therefore recommended that:

C.10 The Superintendent of Insurance should undertake immediate steps together with the insurance industry to explore the implementation of a mandatory basic classification system, at least with respect to compulsory automobile insurance, with a view to its broader application if appropriate. This would take place in conjunction with the elimination of age, sex and marital status criteria as recommended above.

Self-Insurers and the *Compulsory Automobile Insurance Act*

The Task Force was directed by the Minister of Consumer and Commercial Relations to consider the request of the Municipality of Metropolitan Toronto for an amendment to the regulation under the *Compulsory Automobile Insurance Act* to exempt any municipality which maintains self-insurance from the requirements under the Act.

To meet the legislative requirements of the Act, every operator of a licensed vehicle must carry a motor vehicle liability insurance card as evidence of insurance. In order to comply, the Metropolitan Corporation obtained a Standard Automobile Policy from a licensed insurer for automobile insurance coverage. The Corporation also entered into an indemnification agreement with the insurer, which included provision for the repayment to the insurer of the full amount of every claim paid by the insurer under the policy. In effect, therefore, the Corporation is self-insured.

The *Compulsory Automobile Insurance Act* permits any person or group of persons to be exempted from the provisions of the Act subject to such conditions as are set out in an appropriate regulation. One exemption has been made with conditions requiring a plan for financial responsibility, an appointed administrator, an undertaking to pay claims to the same extent as an insurer, and for the issuing of a certificate of insurance.

The Task Force has considered the request by the Municipality for a similar exemption in the light of the current capacity problems in the Ontario insurance market and, in particular, in view of the provincial initiatives to promote self-insurance through reciprocal insurance exchanges.

The Task Force is of the view that municipalities and other public authorities in Ontario have the resources and expertise to establish a plan for self-insurance with suitable administrative and financial guarantees for the payment of claims. The Task Force therefore recommends that:

> **C.11 Municipal corporations and other public authorities in Ontario that establish, either on their own or with other municipal corporations or public authorities, an adequate plan with appropriate financial guarantees to the satisfaction of the Ministry's officials, should be entitled to apply to the Minister for the appropriate exemption from the *Compulsory Automobile Insurance Act*, and the terms of the plan, as approved, should be set forth in the exempting regulations.**

Addendum: Commercial Vehicles

This discussion of the automobile insurance industry must not be viewed as restricted to personal lines. Rather, the Task Force believes that commercial vehicles such as taxis, truckers, rent-a-car fleets, motor coaches and so forth will also benefit from the recommendations set out above; notably, those in respect of the new no-tort personal injury compensation scheme. Vehicles crossing the border into the United States will, of course, continue to encounter serious problems of affordability and perhaps availability, but this issue is dealt with in greater detail above in Part B in respect of the liability insurance crisis.

II PERSONAL AND COMMERCIAL PROPERTY INSURANCE AND OTHER LINES

The personal and commercial property insurance market has certainly not encountered the same degree of structural and cyclical pressures as the liability insurance sector. Nevertheless, the unusually hard market we have experienced has clearly had adverse spillover effects on property insurance and other lines of general insurance. The following discussion highlights the main problems encountered by insureds in this area, and puts forward certain recommendations to address them.

Personal Lines

Personal lines insurance includes homeowners' policies, tenants' packages, and condominium unit owners' policies, together with ancillary coverages to protect specific articles and needs. It also encompasses personal liability insurance, to protect individual consumers against occupiers' liability claims and so forth.

The Task Force is aware of the need for an adequate supply of reasonably priced coverage to protect an individual's investment in both real and personal assets. There is no evidence that such insurance is not readily available throughout the province and that a relatively stable market exists with no apparent capacity problems, other than those associated with specific insurers. Moreover, in comparison to liability insurance, property insurance is clearly viewed as a "safe", desirable line of business. Consequently, there is a high degree of competition in terms of both rates and coverage, and affordability is not a major problem.

The Task Force's concerns are therefore rather limited and relate to certain questions of availability and adequacy of property insurance. For example, individual insurers may decline to provide insurance on an older dwelling regardless of its condition or completed renovations. This increasing selectivity by age appears to restrict the availability of insurance in the older sections of cities and small towns of the province.

In 1965, the Fire, Housing and Legislation Committee of the City of Toronto dealt with similar complaints about the lack of availability of insurance for downtown residential properties. In response, the Department of Insurance and insurance industry representatives established a set of guiding principles, stating in part:

(1) "Rejection of an application or cancellation or refusal to renew a policy because of the physical condition of the property shall not occur without prior inspection of the premises."

(2) "If the property is not insurable because of physical hazards, the owner will be advised by the company, its agent, or its inspector of the specific improvements or repairs that are required to meet reasonable underwriting standards."

These guiding principles provided an effective antidote to the problem that existed at that time. It now appears that the current trend towards "red-lining" by insurance companies is increasing to the detriment of the consumer, and requires a similar response. The Task Force therefore recommends that:

C.12 The guiding principles of the Industry/Government Committee should be reaffirmed and circulated periodically, to remind those in the insurance industry of their obligations with respect to the rejection of an application or cancellation or refusal to renew a policy because of the physical condition of the property, and indiscriminate rejection of insurance applications by reason of area should be discontinued.

Another concern of the Task Force is with the adequacy of coverage. To begin with, there is no single standard policy for personal property coverage in the insurance industry. Each insurer markets its own range of products, providing a multitude of differing forms of protection. While this provides a wide variety of choice for the consumer, it makes it difficult for that consumer to comparison-shop in any meaningful way. In addition, the diversity of coverages creates problems in producing meaningful statistical data by the industry as a whole.

Most personal lines policies providing coverage on buildings or dwellings are written on a homeowners' form. This may be on a "named-perils" basis or on an "all-risk" basis, with little uniformity between the products offered by the various insurance companies active in the province. The premium for such policies is a set premium based on the amount of building coverage, and is not built up from the various components of the policy. This has created difficulties in attempting to establish a breakdown of the premium. Most insurers insist that coverage on a building be maintained to a set percentage of the replacement value of that building.

Many insurers now offer guaranteed replacement endorsements, which protect the consumer in the event that the valuation placed on the building is incorrect. This endorsement ensures that replacement of the building in the event of serious loss will be on the basis of the replacement cost, irrespective of the amount of insurance carried on the building.

In an attempt to encourage a greater choice of options for the insured, the Select Committee on Company Law in 1979 suggested a core coverage as a standard coverage to be offered by all insurers — either as a separate policy or as a component of a wider "package" of coverage. The Committee suggested that the core coverage might be defined as "coverage on the dwelling against fire and all major perils currently provided for in the majority of homeowners' policies, and full replacement cost coverage on the dwelling with no upper limit on recovery or, alternatively, a high upper limit — say $250,000." Further coverages related to protection against liability or contents losses could also be incorporated into the core, if the industry were satisfied that the formulation of these coverages met the needs of a majority of policyholders. It was expected that this concept would aid in the provision of rating data on a more usable basis, as well as providing the consumer with an opportunity to obtain and compare quotes from a number of insurers on a uniform coverage basis.

In its submission to the Task Force, the Consumers' Association of Canada objected specifically to the indivisibility of the coverages and premium in the homeowners' policy. It was argued, for example, that the coverage provided for "outbuildings" or "detached private structures" may not be required and ought to be optional.

The Task Force considers this to be a valid concern and recommends that all insurers consider the provision of composite dwelling policies that allow individual consumers the choice of coverages that they feel they require. The Task Force further believes that it would be useful for the insurance industry to seriously consider once more the Select Committee proposals, and accordingly recommends that:

> **C.13 The insurance industry should seriously consider, on an urgent basis, ways to provide a greater choice of options and flexibility to both the homeowners' and the tenants' package policies.**

Commercial Lines

The reluctance or, in some cases, inability of individual insurers to underwrite commercial property insurance is perceived by the Task Force as being of greater concern than in personal lines. There are some areas where there are only a limited number of markets available; in other areas, individual insurers have retired from writing what to them had been traditional lines; while in yet others, insurers have re-underwritten their entire books of business. All of these, together with price increases, have caused the number of submissions to insurers to increase significantly.

In general, the Task Force has not observed a special problem with availability, although admittedly insurers are placing significantly greater importance on the inspection of individual risks and compliance with subsequent recommendations. This is particularly true with respect to contracts written on an "all-risk" basis where there is, for example, a growing insistence on adequate security systems for most classes of business, depending upon their susceptibility to crime losses. This of course is not an undesirable development. But, though the overall capacity of an insurer has not been reduced, some are limiting growth in particular areas through selective underwriting by class rather than by specific risk.

With respect to the question of affordability, while there have been increases in the costs of commercial property insurance, excluding liability premiums, the Task Force has found that the increases are not extreme. There are of course some exceptions to this generalization, particularly where a policy is moved from the normal market to the residual market. It should be noted parenthetically that the Insurers' Advisory Organization has developed a simplified and more accurate national schedule for property insurance, which allows changes in rates to be more responsive to statistical changes than in the past.

Other Lines

The unfavourable loss experience in commercial insurance is reflected in tighter underwriting with respect to other lines of insurance, including crime insurance, cargo insurance, and the traditional inland/marine coverages. In certain specific areas, such as furriers, jewellers, and contractors, there has been a reduction in the number of markets available in the province. There has also been a gradual worsening of the loss ratio in the surety field. It is understood that this deteriorating situation is under review, and it is hoped that it will soon be corrected.

Aviation insurance suffered the worst year ever for losses in 1985, and it is expected that this adverse loss experience will result in sharply increased rates.

III DISTRIBUTION SYSTEM

The distribution system in Ontario is dominated by the independent brokers and agents who account for about 80% of the market, compared to some 20% for direct writers such as Allstate, State Farm and The Co-operators. (Note that the direct writers insure 25% of private passenger vehicles.) The Task Force has closely examined this system and the extent to which it has aided or abetted the insurance crunch. Although it is clear that the system has served the province well in the past, as reflected in the 1979 Select Committee Report, it is the Task Force's view that it has not been sufficiently responsive in dealing with the major structural and systemic changes that underlie the current crisis. Significant changes are now required in order to maximize the efficient utilization of capacity in the industry, and to adequately service the public needs and demands for new and more complex insurance products and a more stable risk environment. Such changes will be discussed here, as well as in the "Market Regulation" portion of Part D.

To begin, a brief background to the distribution system in Ontario would be useful. The distribution system in Ontario is split into two distinct segments. One segment is comprised of so-called "captive" agents. These are usually employees of a single insurer referred to as a "direct writer". The other segment is comprised of brokers — independent businesspersons who arrange insurance on behalf of a number of insurers. They are generally regarded as acting on behalf of, and owing a fiduciary duty to, the insured. Moreover, the *Registered Insurance Brokers of Ontario Act*, under which general insurance brokers have been self-regulated since 1981, specifies that its members not be involved with any business that would put them in a position to unduly influence the consumer to do business with them.

Most observers will admit that there is a place for both the captive agent and the broker. Captive agents understand the products they sell very well, and they are, in essence, salespersons. They sell a relatively limited range of products, while service is generally provided by the insurer.

In contrast, brokers spend less time in sales. On average, due to the scope of their business, they are not as familiar with all the individual products of each insurer. On the other hand, they have a broader knowledge of a wider range of products. The brokerage system is oriented towards service, as opposed to sales. The ability of brokers to access a sufficient number of insurers has become critical as insurers have become more selective in terms of the range of insurance products offered.

In describing the current distribution system, one cannot ignore the recent trends relating to the emergence of the "financial services" industry — trends that might have the potential to have reasonably dramatic effects on the costs of delivering personal lines insurance to consumers. In theory, the "financial services" supermarket offers one-stop shopping for a variety of financial services products such as automobile, homeowners', and for some, mortgage insurance. For example, the need for homeowners' and mortgage insurance might be identified by the real estate services arm of the supermarket. The concept of buying automobile insurance on a retail store credit card and paying for it in monthly instalments is also beginning to evolve.

It must be noted that the extension of financial conglomerates into general insurance activities may encounter some legal hurdles. So long as insurance products are offered and serviced by individuals who are licensed to do so and the consumer maintains his/her ability to price-shop, it would appear that the activity does not contravene the *Insurance Act* or the *Registered Insurance Brokers' Organization Act* respecting unfair business practices and tied selling. If, however, the premiums for these products are influenced by the number of products the consumer purchases, it may be alleged that coercion or inducements are prevalent that are contrary to the aforementioned Acts. On the other hand, if it can be established that lower premiums are the result of lower costs (and the direct result of synergy which comes from being organized in this fashion) then presumably such marketing does not violate these Acts and, in fact, promotes more innovative delivery systems and mass marketing.

This is a subject on which it is difficult to generalize. Every "financial sources" supermarket may be different, and an assessment of the legalities of their individual activities is well beyond the scope of the Task Force's mandate. It is sufficient to note that financial services conglomerates have the potential to capture a very significant share of the personal lines insurance markets in Canada, and particularly in large urban centres like Toronto. Moreover, for consumers of general insurance products in Canada and Ontario, the opportunity would appear to exist to realize significant benefits from the combination of innovative products and methods of distribution so long as they are not unknowingly shortchanged by the quality of the product and associated customer service. For many of the participants in the general insurance industry in Canada and Ontario, such developments could also be a double-edged sword. Those who are unaligned with such a "full services" conglomerate could find themselves significantly disadvantaged in a marketplace that becomes increasingly "oligarchic" and less truly competitive.

The Problem of Accessibility

As the foregoing description indicates, independent agents and brokers are highly dependent on their relationships with a variety of insurers to ensure access to a sufficient range of insurance products by their clients/consumers. Unfortunately, in a hard market insurers are generally more inclined to terminate what might be perceived as unprofitable relationships with certain brokers and agents. The broker then suffers because he/she is left scrambling to replace the coverage for the insured; the consumer suffers because, among other things, he/she may be classified differently by a new insurer; and the insurer suffers because of the additional costs of terminating the business and (sometimes) replacing it again. This unsatisfactory situation is further exacerbated by the current severe problems in the liability insurance market highlighted in Part B above, whereby certain specialized risks are underwritten by very few insurers.

These are examples of what can occur in a truly competitive marketplace, and one has difficulty in perceiving how the public is well served under such conditions. It is not known how widespread or prevalent this trend is (or has been in the past), but if the industry is unable to reach agreement in its own ranks with respect to a code of conduct or an agency writer/broker agreement that sees the consumer held "harmless", it may seem reasonable to expect that government or regulators will intervene.

In this connection, the Task Force notes that it does not appear feasible to establish a uniform contract form in Ontario due to the disparity in size of brokers and variations in the types of insurance written. Nevertheless, the Insurance Brokers Association of Ontario (IBAO) has issued "proposed guidelines" for broker/insurer contracts setting out the criteria for such contracts. These guidelines include the following recommendations:

(1) The contract should be for a fixed term, preferably two years, and should contain an automatic renewal clause renewing the contract on the same terms, unless notice of non-renewal is given 90 days in advance of the expiry date.

(2) The contract should contain a provision stating that the insurer will not cancel or refuse to renew the contract for the sole reason that the loss ratio of the broker is unsatisfactory.

(3) The contract should contain a provision stating that in the event of cancellation of the contract by either party the insurer will:
    (a) provide for a limited brokerage agreement, following the termination of the contract; and

(b) permit the broker to determine whether existing policies should be reinsured, replaced or continued in force, according to the terms and conditions of the limited brokerage agreement.

The IBAO efforts to self-regulate the broker/insurer relationship are certainly to be commended. But the Task Force is concerned that such efforts may not be sufficient to protect the consumer interest in access to affordable and adequate insurance. The Task Force therefore recommends that:

C.14 The Superintendent of Insurance should monitor the situation closely and work with the Insurance Bureau of Canada, the Insurance Brokers Association of Ontario, and other relevant industry associations to ensure the development, application and enforcement of adequate guidelines to govern the broker/insurer relationship, including the orderly transfer of business from terminated agencies.

C.15 All independent brokers and captive or exclusive agents should be required to disclose to the public the extent of their capacity to sell various types of insurance products and the products of a variety of insurers.

A further means of addressing the problem of accessibility is to encourage networking among brokers. In a number of individual cases studied by the Task Force, it was found that the brokers concerned did not have access to markets that could provide the necessary insurance coverage for their clients. The brokers portrayed the situation as one where insurance was unavailable, when in fact only the knowledge of its availability was inaccessible to the broker. In recent months, it has become all too obvious that the Ontario Liability Insurers' pool has become a surrogate for such a network. Agents and brokers with no access to specialized lines of liability insurance, such as for day care centres and taverns, have flooded the pool with applications.

The *Insurance Act* of Ontario certainly contains no barriers to either formal or informal networking by brokers. The Task Force understands, however, that insurers prefer to write business that originates in the office of the broker under contract. In the interest of providing an expanded market for brokers to better serve their clients, the Task Force recommends that:

C.16 The Superintendent of Insurance should actively encourage the insurance industry to permit and facilitate networking procedures among brokers, provided that the originating intermediaries provide much more accurate underwriting information to those in the network, and that the network be set up in such a way that insurers be approached only once with each submission. Disclosure of networking activities should be part of the procedures to protect against possible abuse of networking activities.

More Effective Communications

Another key deficiency in the distribution network identified by the Task Force is the inadequate communication link between insureds and their broker/agents, and between the broker/agents and insurers. In conducting several in-depth case studies of instances where insurance coverage was either unavailable or difficult to obtain, the Task Force discovered that in many cases the broker was unable to precisely understand both the nature of the risk requiring coverage, and the needs of the insured. This in turn means that the broker/agent was unable to provide the insurer with adequate underwriting information, leading frequently to perhaps ill-considered refusals to underwrite the risk. In this connection, the Task Force is well aware that the quality of the broker/agent applications to the Ontario Liability Insurers' pool were more often than not of less than acceptable quality.

Historically, the educational facilities of the industry have largely concentrated on the needs of company personnel. In later years the Insurance Brokers Association of Ontario has maintained a full-time educational department that concentrates on the needs of brokers and their employees. The Insurance Institute recently introduced a series of courses aimed at intermediaries, stressing consumer requirements and giving insight into market knowledge.

Education along these lines is to be commended, and it is hoped that a greater number of both brokers and direct writers will be encouraged to take advantage of these Institute courses and similar courses offered by the Canadian Federation of Insurance Agents and Brokers Associations.

But there is a clear need for greater expertise on the part of intermediaries, particularly given the introduction of new and very complex insurance products such as the claims-made policy discussed in Part B above. In addition, insurance brokers must be in a better position to explain to insureds the details, for example, of their homeowners' and tenants' packages; condominium unit owners' policies; the special arrangements that could be made for protection againt third-party liability claims; and the possibility of purchasing first-party coverage to cover volunteer activities. Finally, brokers/agents should be much more familiar with risk management and loss prevention.

The Task Force therefore recommends that:

C.17 The Government of Ontario should assist the associations of agents and brokers to offer educational and licensing programs that meet the challenges created by the emergence of new and innovative products and services, and that improve the capacity of their members to assess the soundness of the institutions concerning whose products they advise the consumer. This recommendation was also put forward by the Dupré Task Force.

Another issue arising in respect of the communication problems is the evident failure on the part of intermediaries in the distribution system to utilize present technology and seek out new technology. It is estimated, for example, that less than 50% of all brokers have computers at the present time. Only a few insurers have made available either interface facilities or "stand-alone" microcomputer-based agency management systems. While primarily intended to improve internal systems and efficiency, the systems are also meant to enhance broker office efficiency and the ease with which their brokers can deal with the insurers.

The Task Force is aware of the existence of the Centre for Study of Insurance Operations (CSIO). The CSIO was incorporated in 1981, as a non-profit joint venture between the Canadian Federation of Insurance Agents and Brokers Associations and a number of independent agency insurance companies that write about 60% of the total premiums in Canada. Currently, the CSIO is working on five programs with the goal of increasing the effectiveness and efficiency of the independent agent/company delivery system.

The Task Force commends such initiatives and recommends that:

C.18 The insurance industry should be actively encouraged to pursue joint projects, such as those carried out under the aegis of the Centre for Study of Insurance Operations, much more aggressively.

Inadequate Industry Data Bases

The current insurance crunch is unquestionably exacerbated by the inadequate industry data bases, particularly in respect of liability insurance. For example, while automobile insurers routinely file information such as rate manuals and rate evaluations and report loss statistics according to a uniform statistical plan, similar information in respect of other lines of general insurance is not provided. The deficiency of the data bases will be discussed in further detail in Part D in respect of rate regulation.

The Task Force is of course aware of substantial improvements in the data bases to date. For example, the IBC has improved the Commercial Lines Statistical Plan through additional definitions as to the cause of losses and better coding criteria. And a new schedule rating was implemented shortly after 1979, which today is represented in the IAO's Rapidscan service. More recently, a new general liability statistical plan has been developed by the IBC and will be implemented in the near future.

Nevertheless, it is clear to the Task Force that greatly improved industry data bases would facilitate the underwriting of what are now perceived as difficult liability risks. The Task Force therefore recommends that:

C.19 The Superintendent of Insurance should work closely with the insurance industry, particularly the Insurance Bureau of Canada and Insurers' Advisory Organization, to improve the collection of statistics in respect of non-automobile commercial lines of insurance, and to mandate the collection of specific data and information in a similar way to that currently in place in respect of automobile statistics.

C.20 Strong consideration should be given to the establishment of a body parallel to the United States Consumer Product Safety Commission, which operates the National Electronic Injury Surveillance system (NEISS). All emergency wards of major U.S. hospitals are plugged into the NEISS system, which feeds in data on product-related injuries. In this way a much more effective statistical base and early warning system with respect to potential areas of product liability can be built up. Similar statistics on occupiers' and professional liability should also be collected and analyzed more systematically and comprehensively.

Commission Rate Structure

Another area of concern with the distribution system is that of the commission rate structure. Critics of the structure argue that it bears no resemblance to pay-for-value-received. The percentage commission rate structure predominates the insurance market in Ontario. Normally, the higher the premium, the higher the commission paid to the broker. There is, however, some variance in commission rates at present. For example, in automobile insurance the commission paid for unmarried males under age 23 is lower than for other risks, because of the size of the premiums involved.

On the whole, it seems clear to the Task Force that the present commission structure does not adequately reflect the equation between work done and value received by the insureds. For example, the amount of work involved with the initial application for insurance and the issuance of the policy is normally significantly greater than that which is associated with a renewal in a subsequent year.

Certainly, it would appear that there is scope to change the present system of percentage commissions. Such change should be explored, developed and implemented jointly by the insurers and the brokers. One possibility is a fee-for-service system (to both insurers and insureds) or flat-rate commissions from insurers to brokers with add-ons payable by insureds to brokers for additional services. Such a system would need to include disincentives to prevent insurers from failing to renew the same level of risk and to prevent brokers from indiscriminately moving their book of business and thereby expanding the opportunity for additional services. In the end, the overall cost to consumers might be the same but it could be redistributed in fairer proportion to their needs. And consumers could assess their needs in relation to cost much more accurately.

The Task Force therefore recommends that:

C.21 Insurers and brokers should consider the establishment of a sliding scale for commissions based on class and premium. Such a scale should take into account the amount of servicing required. The changes should be implemented by July 1, 1987, at the latest.

C.22 With respect to large risks, strong consideration should be given to a "fee-for-service" system as an alternative to or in combination with the present commission rate structure, bearing in mind that the acquisition costs to the intermediary, as well as the servicing, risk management and loss prevention costs, are relatively high.

C.23 All independent brokers and captive or exclusive agents should make available to customers upon request the commission schedules that apply to the various lines of property and casualty insurance which they handle.

Providing Capacity and Availability in All Areas of the Province

It would be appropriate to conclude this discussion of the distribution system with a mention of the difficulties encountered in obtaining insurance in remote areas of the province, particularly in Northern Ontario. This subject has been addressed on a number of occasions, notably in the 1979 Select Committee Report in which it was suggested that all insurers be required, as a condition of their licence, to write in all areas of the province and to apply the "take-all-comers" principle. The Task Force recommends that:

C.24 The Government of Ontario should strongly consider the establishment of a government-sponsored residual market mechanism to ensure the availability of adequate, affordable insurance in all parts of the province. Consideration should also be given to the establishment, in conjunction with the insurance industry, of a toll-free province-wide enquiry and placement service.

IV TRANSACTIONS COSTS

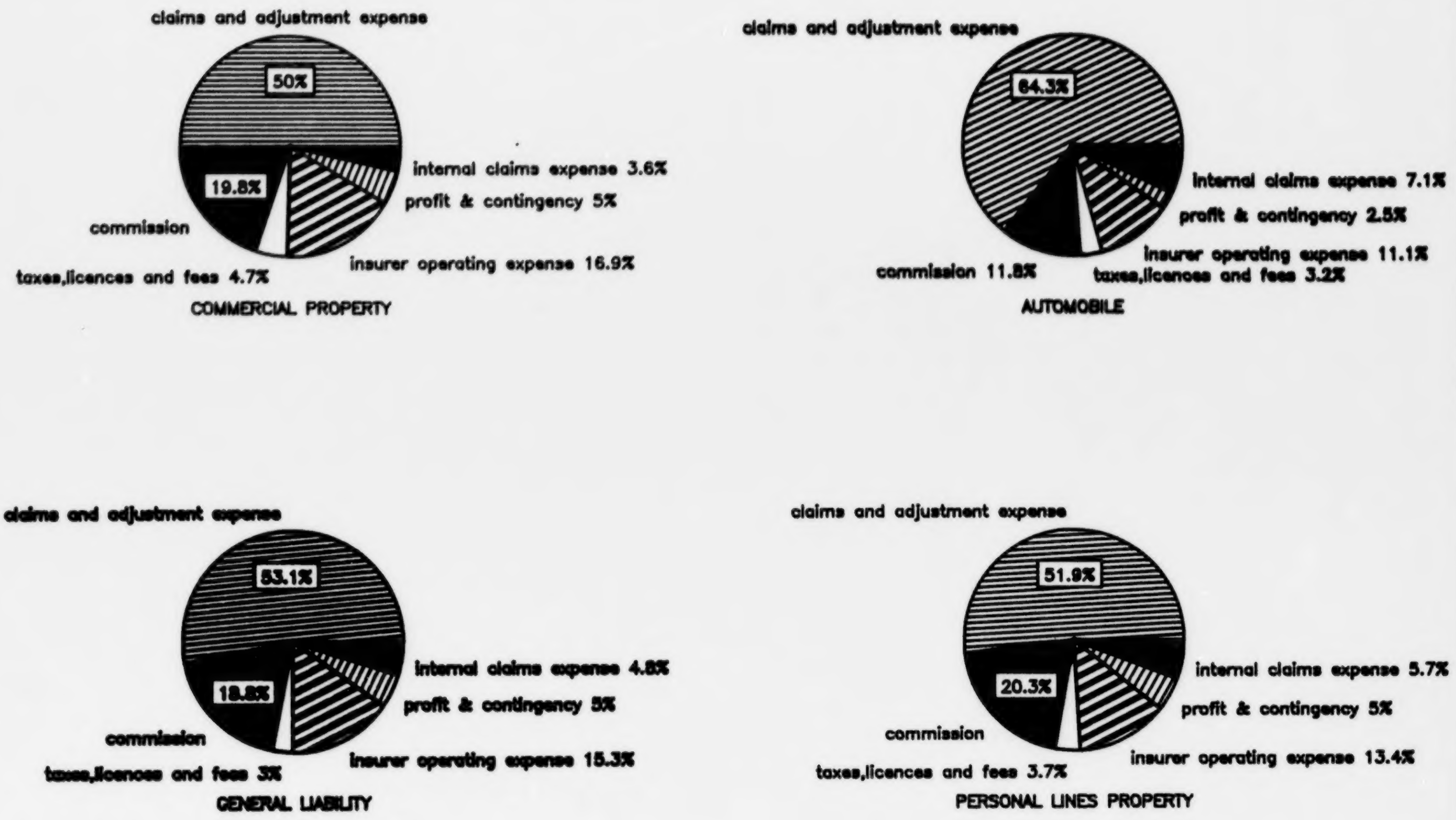
It cannot be doubted that the operations of the insurance industry entail very high transactions costs. While there is no strict consensus on the matter, most people believe that the transactions costs are excessive in relation to the level and quality of service provided.

Transactions costs comprise a number of components. First, there are the costs of selling insurance contracts by insurers, which involve brokers' and agents' commissions, direct selling costs, and the costs of organizing and operating a sales network. Second, there are the costs of administration, and those associated with monitoring and servicing the insurance contracts. Third, there are the claims settlement costs, including legal and adjusting costs. Finally, there are the different costs associated with meeting regulatory requirements, premium taxes, and with administering the investment portfolio.

As the accompanying pie charts indicate, the transaction costs are by no means a trivial proportion of the premium dollar. By far the largest and most troublesome and unpredictable component is that of claims and adjustment expenses (including legal expenses), which amount to 57.6% in personal property lines, 53.6% in commercial property lines, 71.4% in automobile lines, and 57.9% in general liability lines.

In 1979, the Select Committee took issue with the insurance industry's disclosure practices with respect to legal and adjusting costs. It was pointed out that by charging such costs to the claims file and showing them as simply part of the amounts returned to claimants as

COMPONENTS OF PROPERTY/CASUALTY PREMIUM DOLLAR



Source: The Wyatt Company
- Analysis of IBC 1984 Expense Allocation Program Results - Exhibit 1

claims paid, insurers were able to avoid the public scrutiny that such costs merited, and were prone to abuse them. Recommendations were therefore put forward to force such disclosure.

Unfortunately, the extent of public disclosure of legal and adjusting costs has not changed since the Select Committee Report. As noted above, particularly in connection with costs of the tort component of bodily injury claims, the absence of such disclosure has greatly hampered the Task Force in its efforts to assess such things as the relative impact of court awards and settlements on the system and the costs of the distribution system.

At the moment, legal and adjusting costs are not segregated, and are disclosed as an overall amount by both federally and provincially incorporated insurance companies to the respective regulatory authorities. Only portions of these filings for each company are available to the public.

The IBC summarizes data voluntarily submitted by the companies in Ontario that write approximately 80% of all direct premiums. The category of external claims expense does not, however, distinguish between legal fees, adjuster fees, appraiser fees, expert fees, and other external costs. More importantly, even these data are not generally available to the public.

The Task Force, as discussed earlier in a number of sections, finds the absence of empirical data on and analysis of the property and casualty industry to be lamentable, particularly in the liability insurance area. In this connection, it is clearly in the interest of the other users such as the professions, exporters to the United States, municipalities, and all users who have been adversely affected by the insurance crisis to have accurate data of their experience. Insurers must also have this to set price. In particular, components of transactions costs, and segregated legal and adjustment expenses must be identified. The Task Force is also convinced that more meaningful statistics and empirical data are vital to the cost-effectiveness of the insurance system and will permit, for example, much more effective analysis of the factors contributing to increases in claim payments, and a more accurate record of the specific Canadian experience for the purposes of reinsurance.

The Task Force therefore recommends that:

C.25 The Superintendent of Insurance should be directed to work with the Canadian Council of Superintendents to implement the necessary modification to the statutory financial statements to require disclosure, for publication, of segregated legal and adjustment costs, as well as the net percentage of premium dollars returned to claimants in the form of claims benefits for the immediately preceding year.

PART D

THE ROLE
OF
GOVERNMENT

PART D

THE ROLE OF GOVERNMENT

I INTRODUCTION

The insurance industry has generally involved private entities, including joint stock companies, and various forms of mutuals, co-operatives and pools.

The property and casualty insurance industry has long been subject to government interest. The government establishes the regulatory framework within which insurance companies must operate.[1] This extends to the regulation of the insurance contract itself, the market behaviour of participants, and the provision of service and information to the public. It also involves financial regulation relating to solvency matters and other critical financial factors.

Government may also choose to become directly involved in insurance activities through government insurance corporations or, less directly, through facilitating special pool arrangements.

Government concern with property and casualty insurance has greatly increased in recent decades. First, there has been increased concern to ensure that individuals and groups carry sufficient insurance to protect third parties from injury. This has culminated in quite extensive mandatory insurance legislation in respect of a wide range of activities, from day nurseries to professional practice to toxic waste disposal. A list of such legislation in Ontario and Canada is set out in Appendix 6.

Second, government itself, whether federal, provincial or municipal, has expanded its role as a major producer and distributor of goods and services to the public. Government provides roads and airports, municipal services, educational services, recreational and health services, urban and suburban transportation. All these activities generate risks that are a complex mixture of governmental and private responsibility.

The foregoing simply sets out a brief sketch of the extent of direct and indirect government involvement in the property and casualty insurance industry. This Part will elaborate on such involvement. First, the fundamental bases for government interest will be set out. The subsequent discussion will then focus on the nature of financial and market regulation and proposals for change. Reference will also be made to the impact of government on the property and casualty insurance industry through the taxation system. Finally, the Part concludes with a consideration of governments as more active participants in insurance activities, including the possible role of governmental insurance corporations in Ontario.

II FUNDAMENTAL BASES OF GOVERNMENT INTEREST AND INVOLVEMENT IN THE PROPERTY AND CASUALTY INSURANCE INDUSTRY

In discussing the role of government, actual or potential, in the general insurance industry, it is critical first to identify the "public interest"[2] involved in order to provide some guidance for government action. The nature of this public interest has certainly been the subject of much debate in recent months as escalating demands have been placed on government to do something to correct what are perceived to be market pressures out of control. Increases in automobile insurance premiums have hit thousands of Ontarians in their pocketbooks. But even more importantly, the impact of the crunch on liability insurance coverage for all insureds, from manufacturers and municipalities to day care centres and sports and recreational groups, has resulted in cries of "foul play" from almost every niche of the social economy.

The current crisis has highlighted how essential adequate insurance coverage is to the ordinary Canadian, and the pressing public interest in both a stable risk environment and a stable insurance product. The need for a government presence in regulating and supervising the provision and availability of the insurance product has long been accepted. Insurance, defined as the transfer of risk of loss from individuals and organizations to a risk-sharing pool, is quite simply indispensable to modern life. It satisfies pressing needs, both social and individual, for protection. The loss of a home or business premise could be a devastating event in the absence of insurance, and major new investments might not be made without the capability of insuring risks. Certainly, a reduction in risk taking would have far-reaching social and economic consequences in terms of our standards of living, as well as significant individual consequences.

Surprising as it may seem, the general public is only now waking up to the fact that the insurance industry is an essential multi-billion-dollar-a-year component of the financial services industry, and of our economic infrastructure, as well as a critical element in our social and economic lives. Most do not realize that, for example, the consumer ought to be as concerned if not more concerned with the possibility that his insurance company might fail, than that his bank might fail. If his bank fails, he may (or may not, given the Canadian Commercial Bank precedent) lose a portion of his deposit. But if his insurance company fails and he suffers a loss, he stands to lose his house, personal belongings or everything, as the recent experiences with the insolvencies of five insurance companies came close to demonstrating. And in a slightly different context, the impact of the failure of the United Canada Insurance Company on the livelihood of its trucker clients further illustrates the essential role played by insurance companies in our day-to-day lives.

The general insurance industry is one in which there has clearly evolved a mix of state/government and market mechanisms. But this mix cannot be explained simply in terms of the "market failure" concept — that is, that government involvement and interest are triggered only when the private industry is unable to fulfil some essential function. Certainly, market failure may be one basis for government involvement, but other even more important bases include the need to facilitate the pooling of risk and uncertainty, the need to take active measures to reduce the probability of loss, the need to promote the stable functioning of the insurance industry, and the need to address certain redistributive concerns in respect of general insurance activities. It would be useful to discuss each of these bases briefly.

First, the best example of the government interest and involvement on the basis of "market failure" is perhaps the creation of the "Spills Bill" pool and the arrangement with the Ministry of the Environment whereby the government has become effectively the reinsurer of last resort. When it became evident that the private insurance market was unable to provide the necessary pollution and environmental coverage, the government simply had to step in — first, to facilitate the formation of the "Spills Bill" pool for certain limited coverage and then, as the reinsurer for the excess through the Ministry of the Environment. Such action was clearly dictated by the public interest in ensuring protection against the eventuality of a catastrophic environmental pollution event.

The **second** basis for a government interest in general insurance is that of facilitating the pooling of risk, which essentially involves promoting one of the fundamental purposes of insurance — i.e., to allow individuals in society to reduce the uncertainty associated with possible future losses arising from an ever-expanding range of risks. In this connection, it is clear that exposure to risk in today's complex social economy is inevitable and unavoidable, and we must constantly seek new ways to cope with risk. The risk environment is in a constant state of mutation, due to changes in social and living patterns as well as continual economic and technological change and expansion. Our more densely populated centres and increasingly more complex and sophisticated technologies, products and services all contribute to a much greater opportunity for a higher frequency and magnitude of loss. At the same time, rising property values, increasing liability costs and greater financial risks are reducing the ability of individuals and organizations to cope with the potential size of their own losses. Finally, all this is exacerbated by price inflation, economic uncertainty, heightened consumer consciousness, and increased expectations leading to so-called "social inflation".

In identifying the specific objectives pursued by government in facilitating the pooling of risk, the 1979 Select Committee perhaps put it most succinctly as follows:

(1) Insurance must be made available to all who want it and need it.

(2) The insurance product should be of high quality and reliable. For example, contract provisions should be clear and fair; arbitrary cancellations should be prohibited; and consumers should be protected against insurer insolvencies.

(3) Insurance prices should be as low as possible, not subject to large and sudden changes, and fair among policyholders.

The difficulty in promoting such objectives as availability, affordability and adequacy of insurance is, of course, closely related to the intangible nature of the insurance product itself. As the Select Committee pointed out, the purchase of an insurance contract is a promise of protection and future compensation, rather than an exchange for immediately tangible goods or services. In effect, the policyholder buys the future settlement of a claim, but the consumer in most cases is unable to evaluate an insurer's promises of future performance at the time of purchase. In particular, the consumer is unable to evaluate the financial position of the insurance company as an indication of the ability of the company to pay the future claim. Obviously, the consumer needs information and advice with respect to the coverages and insurance carriers competing for his premium dollar in order to properly evaluate such an intangible product. Indeed, the price determination process for insurance is so different from most other products — inasmuch as the price of insurance is based on future costs which must be predicted, and not on actual costs of production, which are the basic determinants of price for most goods and services — that the consumer simply cannot alone judge the fairness or reasonableness of the cost.

The existence of the Office of the Superintendent of Insurance (until recently under the auspices of the Ministry of Consumer and Commercial Relations, and now under the new Ministry of Financial Institutions), together with the supervisory and regulatory powers accorded to the Superintendent of Insurance, is perhaps the most obvious example of government involvement to ensure the availability, affordability and adequacy of insurance. As will be noted in the next section, direct regulation has hitherto focused primarily on financial matters related to the solvency of insurance companies, as opposed to the regulation of the insurance market itself. The insurance industry has been subject to reasonably little interference in terms of the type and delivery of the insurance product. In light of recent difficulties during the current crisis, however, it is clear that substantial changes in the regulatory or supervisory roles are now warranted.

A **third** basis for government involvement and interest in the general insurance industry identified above is that of ensuring that active measures to reduce the probability of loss are taken. It is by now well accepted that the government has a legitimate and important role in helping society cope with the risk environment through government participation in a wide range of public safety and loss-prevention activities. These include police and fire protection systems, fire and building code standards, governmental control over hazardous substances, zoning by-laws that prohibit an accumulation of hazards, and governmental participation in other public safety mechanisms, such as inspections.

In future it would be sensible for the government to take the lead in encouraging a debate over the appropriate balance of responsibility for loss prevention and risk management programs, among individuals and groups, insurance companies and public bodies. In addition, consideration might be given to the promotion of more research and development into product and safety standards, more training of personnel in loss prevention and control, and more public education. Finally, the government will need to ensure more accurate and extensive data collection on the causes and extent of losses of all types.

A **fourth** basis for government interest and involvement is in the promotion of the stable functioning of the insurance industry. The justification for such involvement, at least with respect to financial regulation, has been demonstrated most dramatically with the recent insolvencies of no fewer than five insurance companies. But in addition, the current liability insurance crisis and the lack of availability, or severe problems of affordability in respect of essential insurance coverage, further justifies more government involvement in what may be termed "market regulation".

Proposals for changes in the role of government in financial regulation and market regulation will be discussed further in subsequent sections. Reference has already been made to the need for the government to promote and facilitate a variety of mechanisms to overcome the capacity and availability crunch, particularly in respect of liability insurance.

The **final** basis mentioned above for governmental involvement in the general insurance industry is for the purpose of addressing certain redistributive concerns. Redistributive concerns enter the insurance arena when day care centres, municipalities, hospitals and other collective-good-rendering organizations are put under pressure by high premiums. Inevitably, irresistible pressures are placed on government for relief (by means of public subsidies of premiums, government insurance and so forth), something which is all too evident today. To date, the government has responded to such pressures with the creation of a Market Assistance Program and Hot-Line service, and by facilitating the creation of the Ontario Liability Insurers' (OLI) pool. A number of proposals to relieve these pressures have been put forward in this report based on the assumption that the public interest would be best served if the government uses a variety of instruments to assist, rather than supplant, the private industry in adjusting to the fundamental structural changes that have occurred in the risk environment.

Having now summarized the key bases for government interest and involvement in the general insurance industry, the subsequent discussion will focus on proposals for enhanced financial and market regulation by insurance supervisory authorities. The tax implications of various strategies will also be raised. The final section will describe and assess the various forms of government participation in insurance activities.

III FINANCIAL REGULATION

Types of Regulation

Government presence in the insurance industry has been a fact of life since before Confederation. Regulation has been undertaken through a mix of statutory provisions and administrative rules which can be divided into two broad categories: financial regulation and market regulation.

Financial regulation refers to the controls placed on the structure of insurers, the financial aspects of their operations and their accountability for such operations.

Market regulation refers to the controls placed on the relationship between insurers and insureds and their respective rights and obligations, including contracts of insurance, policies, rates, premiums and insurance delivery networks.

Financial regulation will be dealt with first, and market regulation next.

Under Canada's Constitution, the federal and provincial governments have concurrent jurisdiction over insurance. The federal government regulates the corporate structure and financial standards of federally incorporated insurance companies, the Canadian branch operations of British and other foreign insurers, and provincial companies that have chosen to register federally. Each provincial government regulates the corporate structure and financial standards of provincially incorporated insurance companies, as well as the market operations of *all* insurance companies (wherever incorporated) which are licensed to do business in that province. The activities of federal and provincial insurance regulatory authorities, therefore, are closely intertwined. The recommendations in this Part, of necessity, address matters within federal and provincial jurisdiction because many companies doing business in Ontario are regulated by both levels of government. For the Task Force to confine its recommendations to matters exclusively within the jurisdiction of Ontario would largely negate its thrust.

Financial Regulation Today

The general philosophy of regulation of financial institutions in Canada during most of the last three decades has been to promote and nurture market competition, a large measure of self-regulation and minimum levels of government regulation. Competition and freedom to expand the range of activities, rather than increases in the regulation of deposit-taking institutions, were the central thrust of the Porter Commission reports and the amendments to the *Bank Act* which followed them. The application to the trust and loan companies of this thrust admittedly lagged somewhat behind expectations.

The insurance industries — life, health, property and casualty — have been highly competitive for decades. Though modernization of their regulation was (and is) needed, it was not needed to promote more competition but for other purposes, some of which will be discussed below.

There are significant structural inhibitions to further competition amongst financial institutions and growth. Different types of financial services have been required, by law, to be conducted through separate corporate vehicles whose objects were limited to a particular type of activity. In addition, these corporate vehicles (primarily banks) are subject to ownership controls which make it difficult, if not impossible, to place the different types of financial services under common ownership for the purpose of integrating such services.

The most recent round of study, therefore, began by focusing on how financial services might be integrated and what law and regulatory reform would be required. Other events, however, soon adjusted the focus of study. The last few years have seen most types of financial institutions (banks, trust and loan companies, securities dealers, property-casualty insurers and credit unions) suffer severe financial difficulty, and sometimes failure. This has led to a new emphasis on financial regulation at both levels of government.

At the moment, the principal emphasis of financial regulation of property and casualty insurers is almost exclusively with solvency issues. This partly reflects the fact that during the last five years, Canada has experienced several insolvencies of general insurance companies, as well as a number of mergers and efforts aimed at strengthening of others, after a long record of solvency. It is clear that some adjustments in statutory and administrative controls are required in order to enable the regulatory authorities to better deal with companies in difficulty.

The emphasis on financial regulation of the general insurance industry also reflects the general concerns with changes in other financial institutions, including: integration of financial services and competition; ownership, self-dealing and conflicts of interest; and solvency generally. Financial regulation of these matters can have major implications for the availability and price of various insurance services and for the cycles of adjustment in the future.

It seems clear that both levels of government will be major players in financial regulation indefinitely into the future, although in the current situation there is once again the tugging and hauling between federal and provincial governments regarding regulatory roles for financial services that have gone on at various periods in this century.

For insurers, it is important to recognize the concurrent jurisdiction of the federal and provincial governments, with the federal presence being pre-eminent in matters of solvency (through the regulation of federally incorporated insurance companies or branches of foreign insurers) and the provincial governments being pre-eminent in market behaviour (through the regulation of all matters relating to contracts of insurance, including delivery of services, policies and premiums).

The Task Force must recognize nearly a decade of proposals for changes in the regulation of financial institutions, with little action so far. These proposals are mainly found in:

- the reports of the Ontario Legislature's Select Committee on Company Law in the 1970s, which made a comprehensive set of recommendations for reform of financial and market regulation;
- the 1982 proposals of the (federal) Superintendent of Insurance for revision of the *Canadian and British Insurance Companies Act* and the *Foreign Insurance Companies Act* to increase required capitalization, limit insurance activity in relation to the capital base, regulate more tightly the use of reinsurance, and strengthen regulatory powers;
- *The Regulation of Financial Institutions: Proposals for Discussion*, the Minister of Finance's 1985 "Green Paper", and the Technical Supplement thereto;
- *Eleventh Report of the House of Commons Standing Committee on Finance, Trade, and Economic Affairs*, presented in late 1985 and known as the "Blenkarn Report";
- *Final Report of the Ontario Task Force on Financial Institutions*, released in late 1985 and known as the "Dupré Report"; and
- Bill 108 — An Act to Amend the Insurance Act (which received First Reading in the Legislative Assembly of Ontario on February 12, 1986).

Some other items are also marginally relevant to the issues of regulation of general insurance, including the federal and Ontario proposals for amendments to legislation and regulation of trust and loan companies, the reports on financial regulation by the Ontario Securities Commission, the reports and proposals for change in the Canada Deposit Insurance Corporation and the reports and legislation regarding the regulation of the insurance industry in Quebec.

We will consider the issues, the positions of others and the Task Force position on financial regulation of the general insurance activities in Ontario under three broad headings:

(1) Who may carry on business as a general insurer?
  - Initial and Ongoing Capital Requirements
  - Ownership

(2) What financial activities may be carried on by general insurers?
  - Investments
  - Reinsurance
  - Reserves

- Self-dealing
- Conflicts of Interest
- Policyholder Compensation Funds

(3) How are general insurers accountable for their financial activities?
Both federal and provincial proposals for reform will be considered.

Who may carry on business as a general insurer?

Initial and Ongoing Capital Requirements

Any general insurer intending to carry on business either federally or provincially must meet certain statutory minimum unimpaired capital and surplus requirements. For example, a provincial joint-stock general insurance company must have unimpaired capital and surplus of at least $1 million (federally, the figure is $1.5 million). As a matter of practice, however, regulators have been requiring greater amounts than specified in the statutes for new companies.

Both the Green Paper and the Blenkarn Report propose increases in initial capitalization to $5 million for federally incorporated general insurance companies. The Dupré Report does not propose any quantitative levels, but favours more rigorous requirements. Ontario Bill 108 proposes initial capitalization for all provincially licensed companies of $3 million. The definition of capital would also be expanded under the proposals presented in the Green Paper and the Blenkarn Report to include preferred share and subordinated debenture secondary capital in much the same way as that currently allowed to the chartered banks.

In making specific changes, several considerations require attention. First, existing small insurers should be grandfathered, or given time to attain the minimum standard. Second, appropriate reductions in surplus requirements may be allowed for farm mutuals, particularly as they are backed up by a healthy compensation fund. Third, the initial surplus requirements for new mutuals may be somewhat smaller, if they have strong backup solvency conditions. Finally, scope must be permitted for development of reciprocal exchanges. The Task Force therefore recommends that:

D.1 The statutory initial minimum capitalization requirement should be increased to $5 million for new federally incorporated property and casualty insurance companies and to $3 million for Ontario-licensed property and casualty insurance companies.

D.2 Consideration should be given to the particular situation of existing small insurers, farm mutuals, new mutuals and reciprocal exchanges in implementing the minimum initial capital and surplus requirements.

Insurance companies also are required to maintain assets (including capital and surplus) which are equal to or in excess of their liabilities. In Ontario, the statute contains this simple requirement, while more detailed solvency rules are in the form of in-house guidelines. Federally regulated Canadian general insurance companies are subject to section 103 of the *Canadian and British Insurance Companies Act* (similar rules apply to British and foreign insurers), which requires a margin of assets over and above liabilities, as well as other solvency rules in the form of in-house guidelines. Essentially, section 103 requires that a company's capital and surplus at least equal the sum of: (i) 15% of the liability for unpaid claims, and (ii) up to 15% of the liability for unearned premiums, depending on the company's past and anticipated claims expense.

Most of the recommendations for future regulation of property and casualty insurance companies propose not only a continuation of the section 103 requirement, but also the addition of other constraining financial ratios. The Blenkarn Report, for example, recommended the addition of a new test, proposed by the federal Department of Insurance, which would require a minimum ongoing capital and surplus margin to be equal to the greatest of: (i) the current section 103 test; (ii) 15% of premiums; and (iii) 22% of claims — (ii) and (iii) being allowed a maximum reinsurance credit of 50% for companies not limited to the business of reinsurance. In addition, for all of these ratios, conservative rules of valuation of assets (the lower of cost or market) and valuation of liabilities (particularly reserves for claims and reserves for claims incurred but not yet reported) are mandated.

The effect of these provisions is to limit the scale of the activity which insurers can carry on from any particular capital base. The Task Force is convinced that the general intent of intensifying these restrictions is sound. They can help to improve the likely solvency experience of insurers, though other measures are also required to accomplish that intermediate goal. They can contribute also to a reduction of the instability of the industry, though for this objective also, other measures are required. They do not appear to be so severe as to inhibit property and casualty insurers from continuing to be essentially competitive. Combined with increased initial minimum capital and surplus requirements for new entrants, increased ongoing requirements are expected to result in less fragmentation in the property and casualty insurance industry. The Task Force therefore recommends that:

D.3 The appropriate federal and Ontario legislation concerning capital and surplus margins of property and casualty insurers should be amended to provide that the ongoing capital and surplus margins would have to be at least equal to the greatest of:

(a) the existing requirements of section 103 of the *Canadian and British Insurance Companies Act*;

(b) 15% of the gross premium income of the company during the immediately preceding 12-month period plus the smaller of $500,000 or 5% of the premiums; and

(c) 22 per cent of the average annual amount of gross claims and claims adjustment expenses incurred by the company during the immediately preceding 36-month period plus the smaller of $500,000 or 7% of the said average amount;

provided that, in the case of (b) and (c), a maximum reinsurance credit of 50% is allowed for companies not limited to the business of reinsurance.

D.4 Consideration should be given to the particular situation of small insurers, farm mutuals and new mutuals in implementing the minimum continuing capital and surplus requirements.

It is envisaged that property and casualty insurance companies in the future may be the proprietors of downstream subsidiaries, or part of financial holding companies and subsidiaries of other financial institutions or both. The various reports are unanimous in the view that, in considering the capital requirements of these various interrelated institutions, there not be double-counting of capital. The Task Force strongly endorses this view. The Task Force therefore recommends that:

D.5 The initial and ongoing capital requirements recommended above should be applied to each property and casualty insurer without regard to the capital of other corporations with which it may be related or affiliated.

Ownership

The central debate about permitting narrow ownership or requiring broad ownership of financial institutions, and about permitting common ownership of various types of financial institutions (thereby allowing them to be part of conglomerates) is more relevant to deposit-taking institutions (particularly banks and trust and loan companies), than to property and casualty insurers. Some advocates argue that solvency standards of prudent management, quality and reliability of service and the desirable diffusion of power are greatly enhanced by widely diversified ownership. In view, however, of the recent record of troubled financial institutions in Canada, many of which were widely owned, the case is much harder to make than it used to be.

Other advocates suggest that when control and accountability of a financial institution is in the hands of one or a few readily identified owners, more, rather than less, prudent management ensues. Certainly on recent Canadian evidence, this case has to be given some weight.

Self-dealing, fraud and gross mismanagement can and have occurred in recent experience in both narrowly and widely held financial institutions in Canada, and the Task Force sees no reason to favour one form of ownership over another in this regard. While it is correct that the failures of property and casualty insurance companies have been of narrowly owned organizations, narrow ownership is the dominant characteristic in that sector and thus should not be taken as a causal factor in the failures.

Two other ownership questions regarding financial institutions also are high on the public agenda: whether the combination of financial and non-financial corporations in conglomerates should be allowed, and whether foreign ownership should be controlled. Except for the Green Paper, most proposals anticipate a continuation, perhaps some increase, in the inclusion of property and casualty insurance in financial conglomerates. Indeed, many proposals would not only permit such insurers to be under the umbrella of other financial organizations and financial holding companies, but would also permit some downstream subsidiaries to develop from the base of property and casualty insurance bodies.

There is universal agreement that insurance companies with common ownership must be able to provide reinsurance to each other. The relationship of property and casualty insurers to non-financial institutions within the same corporate group is more controversial. Non-financial bodies have long used the practice of operating captive insurance companies, and under proper conditions this is quite appropriate. General insurance companies are not analogous to deposit-taking institutions which borrow on a leveraged basis. The potential for self-dealing and conflicts of interest between a non-financial institution and a general insurance company, which it may own and control, is significantly less than in the case of deposit-taking institutions.

The property and casualty insurance industry in Canada has long been distinguished by a higher degree of foreign ownership than that of other types of financial institutions. Except for some concerns over the ownership of unregistered reinsurers, a strong sentiment for change does not appear to exist.

The Blenkarn Report is the most useful starting point for considering the ownership issues. It recommends domestic ownership limits for all Canadian-incorporated financial institutions and holding companies controlling affiliated financial institutions based on domestic asset size. Because of their relatively small domestic size (under $10 billion), existing property and casualty insurance companies would not be subject to these ownership limits on an individual basis. However, companies that are part of holding company structures could be subject to the limits indirectly or directly at the holding company level. Also, holding companies could decide to reduce their ownership interests in property and casualty companies as a means to reduce their aggregated domestic asset size, and hence, meet any ownership limits they might face. Foreign-owned Canadian financial institutions, under the Blenkarn Report proposals, would be subject to similar ownership limits based upon Canadian domestic asset size, but this again would have no impact on property and casualty companies because of their small size. Foreign property and casualty companies would still be allowed to operate through branches in Canada, as they are under current legislation.

The whole area of foreign ownership of financial institutions is under review at the federal level. It remains to be seen whether the limitations on ownership of financial institutions, on a stand-alone basis or in conglomerates, will be as liberal as suggested by the Blenkarn Report. The early indications are to the contrary so there is some uncertainty about the effect on property and casualty insurers.

Given the competitive nature of the industry, with many small insurers as well as some medium and larger ones, and given the need for more capacity, it does not appear to make much sense to restrict severely the ownership of property and casualty insurers. The problems of solvency, instability, and prudent behaviour can be tackled in other ways more effectively. The Task Force therefore recommends that:

D.6 The federal and provincial governments should retain their current approach to foreign ownership of property and casualty insurance companies.

What financial activities can be carried on by general insurers?

The statutes under which insurance companies are incorporated generally restrict the objects of such companies to the business of insurance, which is *per se* a broad area. Companies, however, do specialize because each Canadian jurisdiction has a regime whereby companies are licensed, by the regulatory authorities, for certain classes of business (e.g., property, aviation, surety, boiler and machinery).

The Task Force agrees with maintaining the separate identity and functions of financial institutions, particularly for property and casualty insurers. The Task Force, however, supports reform which would allow "networking" as described in the Green Paper and the Blenkarn Report, i.e., arrangements among financial institutions under which one of the institutions provides the public with access to a product or service offered by any other institution. The Task Force also agrees with the related prohibition on tied sales. The Task Force therefore recommends that:

D.7 Statutory and regulatory roadblocks to networking among the different types of financial institutions should be removed and appropriate statutory prohibitions on tied selling should be implemented.

Investments

The kinds of assets that an insurer may hold are regulated to promote adequate liquidity and stability of asset values over time, and to limit potential losses. The current statutory rules use qualitative criteria to prescribe permissible involvements. Pressure for new rules has come largely from life insurance companies who seek greater flexibility in competing with deposit-taking institutions.

The Task Force supports the general direction for change in the investment rules pertaining to financial institutions as outlined in the Technical Supplement to the Green Paper, which involves a change from qualitative to quantitative measures and, in particular, supports the statutory recognition of the fiduciary duty of such institutions' boards of directors in maintaining prudent investment practices.

The most flexible proposals for new investment rules for property and casualty companies have been proposed by the Blenkarn Report, as follows:

Debt securities and quality mortgages	no limit

Real estate for investment (including subsidiaries)	35% of equity
Real estate for own use (including subsidiaries)	35% of equity
Common stocks	100% of equity
Common stocks of venture capital corporations	10% of equity
Total common stocks, preferred shares and real estate combined	150% of equity
Subsidiaries:	
Financial	no limit
Non-Financial	5% aggregate of assets with maximum of 2% assets in each individual subsidiary
Basket Clause	15% of assets

The view of the Insurance Bureau of Canada that the current rules should not be changed for property-casualty insurers is noted. The IBC has suggested that the portfolio approach might result in a greater number of inappropriate investments, which in time might contribute to deficiencies in the assets of insurers. In the Task Force's view, there is nothing inherent in a quantitative or portfolio approach that would encourage such a result and, on balance, the portfolio approach is preferable because of its flexibility. The Task Force therefore recommends that:

> **D.8 The investment provisions of the legislation governing federally regulated companies and Ontario-incorporated companies should be amended to incorporate prudent management standards and the detailed quantitative, not qualitative, limits proposed in the Blenkarn Report.**

Reinsurance

It has been indicated at several points in this Report that spreading risks from primary insurers to reinsurers is a central feature of insurance management. Some parts of this network involve associated companies and there is no good reason to disturb the use of such channels. Consideration must be given, however, to two aspects of the use of reinsurance by Canadian insurers.

Some Canadian companies retain very little, if any, of the risk associated with the contracts of insurance that they write. A variety of reasons explain this outcome. In some cases, a company may only be able to provide a market for certain types of insurance (e.g., ocean marine or professional liability) if it can spread the risk widely through reinsurers. In other cases, Canadian-registered companies may simply be used as a conduit for business for companies that are not registered in Canada, with resulting regulatory problems. There is a strong case to be made for reducing the ability of primary insurers to act simply as fronting companies through the introduction of retention limits, while respecting the operation of those companies that provide specialized liability markets.

The Task Force has considered the various proposals with respect to minimum levels of retention of gross premiums written. It notes that the Insurance Bureau of Canada has suggested retention limits as high as 50%, which, in the Task Force's view, would put some companies providing valuable specialty liability markets in a difficult position. The Task Force therefore recommends that:

D.9 Each primary insurer, where appropriate, should be required, by statute or by regulation, to retain a minimum percentage of its total gross premiums written, such percentage to increase in prescribed amounts on an annual basis over a specified number of years until it reaches at least 25% of such premiums.

The Task Force expects that the regulatory authorities will continue to monitor the use of reinsurance in the industry generally and will increase the retention limit when necessary and feasible, having regard to the various circumstances in which insurers conduct business.

The second aspect is the degree of reinsurance written by reinsurers that are not registered to do business in Canada (and thereby are outside the reach of the Canadian regulatory system). Many unregistered reinsurers are stable and secure companies to which Canadian primary insurers should continue to have access. Some unregistered reinsurers, however, give cause for concern in both their operations and solvency.

Two proposals have been made to regulate unregistered reinsurance. The Green Paper proposed that property and casualty insurance companies be prohibited from placing more than 50% of their reinsurance with reinsurance companies not authorized to do business in Canada. The Blenkarn Report recommended that the amount of premiums that a property and casualty company, other than a reinsurance company, could cede to a non-registered insurer should be limited to the amount of premiums ceded to a registered company. In the Task Force's view, neither of these recommendations focuses on the critical element, which is the security that a reinsurer has in Canada for the purpose of backing up its obligations to Canadian primary insurers.

Registered reinsurers will have certain security available in Canada in order to meet the requirement of federal registration or provincial licensing. Unregistered reinsurers may or may not have security in Canada, depending upon their methods of operation.

The Task Force is of the view that more consideration must be given to ways of either requiring or encouraging unregistered reinsurers that do business with Canadian primary insurers to put in place in Canada adequate security to meet their obligations to Canadian primary insurers. The Task Force is not prepared to recommend that the regulatory authorities implement either of the Green Paper or Blenkarn Report proposals at this time. The Task Force therefore recommends that:

D.10 The federal and Ontario Superintendents of Insurance should give early priority to a reconsideration of the statutory and administrative rules or guidelines governing reinsurance provided by non-registered reinsurers with a view to increasing the degree of security maintained by non-registered reinsurers in Canada in respect of their obligations to Canadian primary insurers.

The Task Force recognizes that, in implementing the minimum continuing capital and surplus requirements recommended in D.3 above, primary insurers will be allowed a reinsurance credit limited to 50%. This may seem to contradict the 25% retention rule recommended in D.9. Supervisory authorities, who monitor the use of reinsurance closely, will be in a position to recommend increases in either the retention level or the credit depending upon improvements in strength of the reinsurance provided to Canadian primary insurers.

Reserves

One of the most important requirements of a responsible, stable general insurance industry is the calculation of, provision for and certification of reserves against claims incurred but not reported, and other contingencies.

The Task Force commissioned a paper on this subject by The Wyatt Company, and endorses its proposal for the more systematic development and application of agreed actuarial methods to this activity (see Appendix 8). The Task Force also endorses the proposal that has been made in several studies and briefs (including the 1982 proposals of the federal Superintendent of Insurance, the Technical Supplement to the Green Paper and the Blenkarn Report) that property and casualty insurance companies submit reports by an actuary or other qualified person to certify that provision made for unpaid claims represents a fair and reasonable estimate of the amount that will be required to settle the claims. Such a step has already been successfully taken in Quebec.

A similar report should be required with respect to the adequacy of a company's unearned premiums to cover claims that may be reasonably expected to occur during the unexpired period of the policies in force. A transition period may have to be given by the regulatory authorities, allowing companies to appoint a person other than a fully qualified actuary if the services of a fully qualified actuary are not available. This will have the benefit of forcing an explicit recognition of the "premium deficiency" item on insurers' balance sheets, something which is already implicitly recognized in their internal rating and planning procedures. In addition, this should encourage the establishment of insurer stabilization reserves that could serve to moderate the huge premium surges that have been witnessed to date. In fact, there is a very limited number of qualified property and casualty actuaries, and it will take some time for a sufficient number to become qualified. The Task Force urges that the appropriate educational and professional bodies take immediate steps to attract and train such actuaries. The Task Force therefore recommends that:

D.11 Property and casualty insurance companies should be required as soon as possible, subject to appropriate transitional provisions, to appoint a valuation actuary and to include with their annual statement and financial statements a report by the actuary certifying that the provisions for unearned premiums and unpaid claims are adequate.

Further consideration should be given to authorizing the Superintendents to request the filing of loss development triangle analyses from some or all companies in order to allow the Superintendents to monitor reserving practices and the development of reserves.

Self-Dealing

Self-dealing refers to non-arm's-length transactions between a financial institution and its affiliated institutions or controlling interests. As a general proposition regarding regulation of financial institutions, self-dealing has been a factor in a large proportion of the insolvencies, bankruptcies and other extreme difficulties of financial institutions other than property and casualty insurers. Banning it or controlling it strictly, along with requiring thorough disclosure, is strongly supported in every set of proposals. The Dupré Report advocated a prohibition on all non-arm's-length transactions unless true market value of the investment can be objectively ascertained by independent means. It recommended that consent be obtained from the Superintendent of Insurance for insurance transactions which involve self-dealing, it having to be demonstrated that the transaction is in the best interests of the corporation. Moreover, it recommended that every exemption made by consent would require disclosure by the Superintendent to a standing committee of the Legislature.

The Green Paper proposed an outright ban on all non-arm's-length transactions between a financial institution and its affiliated institutions or controlling interests. A modest purchase or sale of service in the order of 1% of total expenses or revenues and relatively modest loans to officers and directors would be exempted from this ban. Other limited exemptions would also be considered, including special considerations for reinsurance arrangements between affiliated and related insurance companies.

The Blenkarn Report recommended that financial institutions be permitted to engage in non-arm's-length transactions except those that are likely to have a significant impact on an institution's solvency. These prohibited transactions would be set out in regulations governing each of the major sectors of the financial services industry, after consultation with professional associations and representatives from financial institutions. All financial institutions would also be required to establish a committee of the board with responsibility for reviewing and approving these types of transactions. Such a flexible approach to self-dealing could be important to the property and casualty insurance industry because a large number of insurers are members of an affiliated group that uses inter-company reinsurance in order to spread the risk among its membership. A ban on internal reinsurance transactions would force many companies to seek reinsurance in world markets even more than at present, with the result that any difficulties in obtaining it might cause them to limit underwriting, thereby affecting the supply of insurance in Canada. The Task Force therefore recommends that:

D.12 Property and casualty insurance companies should be permitted to engage in non-arm's-length transactions except those that are likely to have a significant impact on a company's solvency.

D.13 The prohibited transactions should be set forth in regulations under the appropriate federal and provincial legislation.

D.14 All property and casualty insurers should be required to pass a by-law establishing a committee of the board with responsibility for reviewing and approving all non-arm's-length transactions.

Conflicts of Interest

Major conflicts of interest appear to be less likely within the general insurance field than, for example, in the trust and loan field, where the roles of trustee and financial intermediary could severely clash. Nevertheless, conflicts will arise among customers or claimants of insurers, or between insureds, brokers and agents and insurers. They can also arise between a general insurance operation and other operations within a financial conglomerate. A particularly important set of potential conflicts can arise between property and casualty insurers and brokers and agents.

The approach to potential problems should include the creation of "Chinese walls" between fiduciary activities and other operations, increased corporate disclosure and increased public access to remedial action. In a program of regulatory reform, the specific rules and procedures for each sector of the financial services industry would be left to the federal and provincial regulatory authorities. Guidelines for increased disclosure of information would also be developed to enhance the ability of consumers to make informed choices in view of the increased possibility of conflicts of interest resulting from product bundling, corporate affiliations and networking. These aspects of conflicts are especially important for property and casualty insurance. The Task Force therefore recommends that:

D.15 Property and casualty insurance companies should be required to create and maintain "Chinese walls" to prevent the flow of information between certain departments within a company or between affiliated companies where the flow

of information might give rise to conflicts between: (i) the interests of customers or claimants of the company; (ii) the interests of a customer and those of the company; or (iii) the interests of a broker or agent and those of the company.

D.16 The federal and provincial regulatory authorities should consult with trade associations, professional groups, insurance companies and consumer groups in developing guidelines for increased institutional disclosure of information to consumers in view of the increased possibility of conflicts of interest arising from product bundling, corporate affiliations and networking.

Policyholder Compensation Funds

The Task Force strongly recommends the mandatory membership of insurers in Compensation Plans as a condition of licensing to carry on business. The Dupré Report favours the development and implementation of industry-operated compensation funds, membership in which would be a condition of licensing in Ontario. The Blenkarn Report recommends that a separate fund be established for general insurance (along with one for life insurance) and that participation in the fund be made mandatory for all federal companies and optional for provincial companies that met the standards set by the fund. The fund, under Blenkarn's proposals, would be financed by the industry, but would be administered by a national regulatory authority or corporation. Ontario Bill 108 proposes an industry-funded post-assessment fund to operate nationally through a compensation corporation.

The compensation fund proposed in Ontario Bill 108 is quite far-reaching, prompted as it is by the recent insolvencies of The Pitts Insurance Company, Strathcona General Insurance Company, Northern Union Insurance Company Limited, and Northumberland General Insurance Company, and the rehabilitation of Canadian Great Lakes Casualty and Surety Company Limited. A Compensation Corporation would be established, the members of which would include all general insurers licensed by participating jurisdictions. Elected representatives of the industry would sit on the board of directors, while the Superintendents of Insurance would be *ex officio* members of the board.

The aim of the Fund is to assist claimants in the "personal lines" business rather than to cover typical commercial risks. Therefore, certain types of specialized insurance will be excluded from coverage, such as errors and omissions, and directors' and officers' insurance.

The extent of compensation is limited in the following way:

- A cap on payment of $200,000 per claim. (Note that approximately 98% of claims are under this amount and that this is the uninsured motorists' limit.)
- A deductible of $500 per claim. (Note that the intention is to hold the broker, *not* the insured, liable for the deductible, thereby putting the onus on the broker to more thoroughly investigate the financial state of the insurer. The *quid pro quo* is increased disclosure of financial information as noted above.)
- Provision that payment be made only after proper determination of the insolvency of an insurer. (Note that the federal government will have to amend the *Winding-Up Act* to change the priorities of claims and unearned premiums.)
- A post-assessment system backed by a $10-million line of credit. This will be based on the total direct premiums related to the covered business a member has written in the jurisdiction where the insolvent company was licensed.

The Task Force notes that the proposed compensation fund legislation also contains additional financial requirements for all property and casualty insurers licensed to do business in Ontario. These include:

(1) an established ratio of gross written premiums to paid-up capital and surplus, and of net written premiums to paid-up capital and surplus;

(2) actuarial evaluation as to the adequacy of provisions made for unearned premiums, unpaid claims and claims adjustment expenses;
(3) limits on amounts that may be permitted to be due from agents of the insurer, in relation to its paid-up capital and surplus, and also from subsidiaries and affiliates of the insurer;
(4) the necessity of maintaining assets in the form of authorized investments in excess of the outstanding liabilities of the insurer, to be prescribed by regulation; and
(5) prescribing a maximum portion of risk that may be reinsured with unlicensed insurers, as to each different classification of insurance.

The Task Force commends the foregoing initiatives to establish a compensation fund and to implement related regulatory requirements as important steps in promoting stability in the insurance market. The Task Force, however, questions whether an industry-operated fund is the most desirable model.

The problems faced by a contingency fund operated solely by the industry include the setting and enforcement of standards across all jurisdictions and the need for an adequate fund to protect policyholders against major defaults. Because of variations in standards, monitoring and surveillance across jurisdictions, it will be difficult to set more than minimal standards that would be acceptable to all jurisdictions. Furthermore, early detection and correction of difficulties should be a primary goal of the fund. Either the fund operators themselves or the regulatory authorities on their behalf will have to exercise monitoring, surveillance, and animation of corrective action. Without a fund established by pre-assessment, the industry could face a financial crisis if a major default had to be absorbed over a short period of time, and would probably have to turn to governments for assistance. These were the reasons behind the Blenkarn Report proposals.

If there is no provincial and industry support for federal government initiation with respect to a compensation fund, then the Task Force recommends that Ontario take the initiative and create a fund for property and casualty insurers. A mixed funded and pay-as-you-go basis appears to be the most appropriate model. Ontario would have to undertake or cause to be undertaken the regulatory activity required for such a fund. The Task Force therefore recommends that:

D.17 A federal policyholder compensation fund for property and casualty insurers should be established as soon as possible and membership in such a fund should be mandatory for Ontario-licensed property and casualty insurers.

D.18 If the Government of Ontario determines that a federal fund is not to be formed, the Government should establish a fund for the protection of policyholders in consultation with the industry, and membership in such a fund should be mandatory for Ontario-licensed property and casualty insurers.

D.19 Any fund established should be funded by both regular assessments to allow accumulation of funds and special assessments based on experience.

It follows from the requirement that all Ontario-licensed property and casualty insurers participate in a compensation fund that the fund itself will be exposed to varying levels of risk depending on the financial strength and stability of each company. The challenge in structuring such a fund is to build in incentives to member insurers to increase their strength and stability. In setting assessment levels, the claims experience of each particular company and the actual cost of supervising and monitoring each company should be considered.

How are the insurers accountable for their financial activities?

Substantial financial information is already collected by the Superintendents of Insurance, largely through the filing of annual statements in the form prescribed by the Superintendents (currently it varies somewhat across jurisdictions) and through examinations. These accountability mechanisms historically have focused on the solvency, financial practices, stability and growth of *individual* insurers.

It has become apparent that, in some cases, statements should be filed more frequently in order to allow regulatory authorities to monitor the financial position of a company more closely. The federal Superintendent of Insurance made a proposal in 1982 that the appropriate legislation be amended to require any company to file interim financial statements in such detail and with such frequency as required by the Superintendent. Such statements would have to be filed within 45 days after the closing date of the period to which the statements pertain (90 days in the case of reinsurance). The Task Force agrees that regulatory authorities should have such powers, and recommends that:

D.20 The appropriate federal and Ontario legislation should be amended to authorize the respective Superintendents of Insurance to require the filing of interim financial statements from such companies, in such form and with such frequency as required by the Superintendent.

Portions of the annual statements of federally regulated companies are currently available to the public. The portions kept confidential are the section 103 solvency test calculation, the investment valuation reserves and the loss development by year.

The Task Force is informed that federal and provincial supervisory officials are developing a new uniform annual statement that will be an enhancement of the federal form and that will require all insurers to adhere to "generally accepted accounting principles". The Task Force therefore recommends that:

D.21 The federal and provincial regulatory authorities should expedite completion and implementation of the new uniform annual statement, and all parts of such annual statement should be made available to the public in a cost-efficient form.

There have been suggestions that the Superintendents of Insurance should release information on the terms and conditions of companies' licences, as well as information on which companies have been placed on the "watch" list. The Task Force is of the view that the companies and the regulatory authorities involved should be given every opportunity to resolve problems in a private and responsible way. The Task Force emphasizes, however, that better disclosure to the public (both in terms of content and frequency) and the establishment of compensation funds must be put in place in order to ensure that the public is accorded the maximum degree of protection consistent with preventative and rehabilitation efforts by the industry itself or regulatory authorities.

Beyond the questions concerning individual companies and consumers, however, are the problems of obtaining information on a number of critical aspects of the industry's operation, in particular:

- overall profitability;
- profitability by lines of insurance and by various geographic regions;
- elements of operating costs, including selling, claims adjusting, legal and various administrative and transactions costs; and
- differences in operating costs among various lines of insurance.

Certainly, immediate changes to the nature of financial reports made available to the general public are essential. In this connection, it would be desirable to make use of the permanent federal-provincial consultative mechanism consisting of a council of ministers responsible for financial institutions, as recommended by the Dupré Report, to formulate co-ordinated and uniform reporting and disclosure requirements. The Task Force therefore recommends that:

D.22 A permanent federal-provincial consultative mechanism consisting of a council of ministers responsible for financial institutions should be established and early priority should be given to establishing new industry-wide reporting and disclosure requirements with respect to critical aspects of the industry's operation, in particular:

- **overall profitability;**
- **profitability by lines of insurance and by various geographic regions;**
- **elements of operating costs, including selling, claims adjusting, legal and various administrative and transactions costs; and**
- **differences in operating costs among various lines of insurance.**

IV MARKET REGULATION

Introduction

The governmental interest in the availability, reliability and affordability of insurance, as implicit in the Terms of Reference of the Task Force, carries with it an implicit interest in the operations of the insurance marketplace.

The Task Force has explored the operations of the insurance marketplace, with a view to making recommendations in connection with its enhanced performance. The issue remains as to the extent to which government must, or should, be involved in the operation of the marketplace.

The Insurance Contract

The property and casualty insurance industry is basically responsive rather than innovative in the design of insuring agreements. Nevertheless, in recent years, the insurance industry has responded to the changing needs of both corporate and individual consumers by the development of policies to cover such things as strikes, kidnappings, extortion, adverse publicity, takeover attempts or tender offers, tax interruptions and computer crime.

Most consumers already have personal liability protection through their homeowners' policies, and such policies are readily available in Ontario at reasonable cost.

As has been previously noted, the insurance product is an intangible. It is a promise to pay or to respond to an event that might happen in the future. It is embodied in the insurance contract. It is essential that the insuring agreement, as a legal contract, clearly define the rights and obligations of both parties in legal terms that can be reviewed by the court process. This contract may be the most important contract that an insured enters into in his lifetime.

Under the provisions of the Ontario *Insurance Act*, insurers have the right to develop their own contractual forms, with the exception of the automobile policy forms, and are to be encouraged to develop additional types of insuring agreements designed to meet the needs of their insureds. The existing provisions of section 94 of the *Insurance Act* should be maintained, thereby giving the Superintendent of Insurance the right to require the filing of any insuring agreement with him and to investigate and report any case where an insurer issues a policy or uses an application that is, in the opinion of the Superintendent, unfair, fraudulent or not in the public interest, to the Minister — who, if he concurs with the report, may order the Superintendent to prohibit the use of such policy or application. The Task Force therefore recommends that:

D.23 The right of insurers to design insuring contracts to meet consumer needs without prior approval should be continued, and the right of the Superintendent of Insurance and Minister to disallow contracts that are unfair, fraudulent or not in the public interest should be maintained.

Brokers and Agents

The Task Force is aware of the remoteness of the primary insurer from the consumer. To many consumers, the intermediary they deal with is the insurer. This places a heavy responsibility on intermediaries to communicate effectively with both the primary insurer and the consumer. Consumers have indicated the feeling that the primary insurer is unresponsive to their changing needs. Certain intermediaries share this concern.

Some insurers have formed insurer-intermediary committees to consider relationships between themselves and consumers, to strengthen communications, and to allow insurers to become more responsive to their clients. The Task Force therefore recommends that:

D.24 All primary insurers should establish committees with their brokers that will develop mechanisms responsive to consumers and strengthen communication.

Small and medium-sized commercial and industrial insureds are, in most cases, not in a position to have their own risk managers. Further, there are programs of risk management that are utilized only for the direct customers of the various insurers, major brokers and associations involved. The Task Force is aware of the expertise that lies within the Ontario Risk and Insurance Management Society with respect to the benefits of risk management services.

There is, however, a lack of direct response to the public in general, a lack of co-ordination in advice and approach, particularly to those purchasers of insurance who have been severely affected in the liability insurance field. It is important that all intermediaries be familiar with the principles of risk management, as well as being aware of the loss prevention services that can be provided. By judicious use of the principles of risk management and loss prevention, insurance costs can be controlled to some extent, and risk exposure reduced and dealt with more effectively. The Task Force therefore recommends that:

D.25 The Insurance Bureau of Canada and The Insurers' Advisory Organization, together with the Insurance Brokers Association of Ontario, should accept and adopt as their mandate the promotion of risk management services through appropriate arms of the insurance industry, in order that public education of risk management services and loss prevention control can be co-ordinated, promoted, and the public assisted, particularly those insureds facing difficulties with respect to liability insurance coverage.

Governments have historically assumed responsibility for protecting the public from losses. This includes police and fire protection systems, fire and building code standards, government regulation of hazardous substances, zoning by-laws that prohibit an accumulation of hazards, and government participation in other public safety mechanisms, such as inspections.

Insurance companies take account of the level of fire protection services in a municipality in determining the cost of property insurance coverage. There is arguably no reason why a greater focus on risk management programs, loss control through hazard identification, pre-loss inspections, etc., could not permit similar premium differentiation in respect of all types of liability insurance. The Task Force therefore recommends that:

D.26 The Government of Ontario, through the Interministerial Committee established to deal with property and casualty insurance problems, should take the

lead in encouraging a debate over the appropriate balance of responsibility for such loss prevention measures among individuals or businesses, insurance companies and public bodies.

D.27 The Government of Ontario should promote more research and development into product and safety standards, more training of personnel in loss prevention and control (see, for example, the IAO's School of Loss Control Technology), and more public education. Finally, the Government should require more data collection on the causes and extent of losses of all types.

Superintendent's Role

The Task Force, in making the foregoing recommendations (D.24 to D.27) concerning brokers and agents, is cognizant of the fact that the changes in the distribution system that it has recommended are a fundamental part of the structural changes necessary to deal with the current problems of availability, reliability and affordability of insurance contracts in the province. Without such changes being made, there will not be a clear and demonstrated response by the insurance industry to meet the current essential needs of the consumers endeavouring to utilize the system. The Task Force therefore recommends that:

D.28 The Superintendent of Insurance should include in his annual report to the Minister a special report with respect to the progress of industry associations towards achieving the necessary structural changes to the system encompassed in the foregoing recommendations.

Advance Notice of Changes

The basic insurance contract is provided through an agent/broker to an insured, generally through an annual contract. The agent/broker assumes responsibility for renewal, and is the main contact with the insured. As recent events have illustrated, changes in price can occur much more frequently than annually, and the startling effect of a substantial price increase occurs at the time the insured receives notification from his agent/broker. In a similar fashion, deletion of coverages, increases in deductibles and the addition of exclusions under an insurance contract add to the pressure placed upon an insured in a short period of time to accept or reject the contract as offered through his agent/broker.

The situation with non-renewal has been demonstrated to be equally severe; in many instances, the agent/broker is left in a position of not knowing whether a renewal of an existing coverage in a very restricted market will be forthcoming.

The Insurance Bureau of Canada issued to its member companies guidelines for handling non-renewals of personal lines policies in October 1976. Although similar guidelines might be considered for commercial lines policies, there is some suggestion that primary insurers often do not know until very close to the renewal date whether reinsurance will be available. Primary insurers would be at a distinct disadvantage if they had to decide whether or not to extend coverage in advance of a reinsurer's decision.

Problems similar to those in Canada occurred in the United States long before they surfaced here.

As a first step to deal with the lack of insurance coverage many industries were facing, some states passed new regulations with respect to non-renewals and to prevent insurance companies from cancelling policies in midterm without adequate notice. Critics, however, felt that such actions would make insurers more reluctant to write risks in those states, and would cause some to leave states, adding to the lack-of-capacity problem.

Until now this has been a routine marketplace activity that has generally been well handled by both brokers and insurers. Government regulation in this area, e.g., to force statutory notices of non-renewal, could well exacerbate this system and force insurers to come to premature decisions. Nevertheless, insureds must be kept adequately informed of changes. The Task Force therefore recommends that:

D.29 The insurance brokers (through their association, the Insurance Brokers Association of Ontario) and the insurers (through the Insurance Bureau of Canada), under the aegis of the Superintendent of Insurance, should develop guidelines which will ensure timely notification to insureds of changes in price, coverage, exclusions and non-renewal. This recommendation is made on the basis that marketplace guidelines would be the best solution but on the express understanding that failure to arrive at a solution would result in a mandated standard, in each instance, by government regulation.

Rate Regulation

Regulation of insurance rates in Ontario exists only in the case of the Facility Association (the automobile residual market, which is discussed in Part C). It has been proposed by various interested parties in Ontario as a stabilizing factor. It is inexorably linked to solvency regulation of individual insurers. While it appears that the provinces have authority to legislate with respect to rate regulation, it must be borne in mind that the majority of insurers operating in Ontario are federally regulated with respect to their solvency.

In this area, the Superintendent of Insurance continues to rely principally on moral suasion to resolve problems in the industry, backed by the implied threat that the unproclaimed sections of the *Insurance Act* extending his authority over unfair and discriminatory rates could be proclaimed if moral suasion fails.

Once again, however, the Superintendent is also hampered in his efforts by the nature of the information he receives. For example, while some major automobile insurers voluntarily file information such as rate manuals and rate evaluations, information on other lines of general insurance is not provided in a similarly consistent fashion. And with respect to loss statistics for various types of general insurance, reporting according to a uniform statistical plan is mandatory in automobile lines, but not in property and casualty lines.

The Task Force is of course aware of substantial improvements in the data bases to date. For example, the IBC has improved the Commercial Lines Statistical Plan through additional definitions as to the cause of losses and better coding criteria. New schedule rating was implemented shortly after 1979 which is today represented in the IAO's Rapidscan service. More recently, a new general liability statistical plan has been developed by the IBC and will be implemented in the near future.

It is also important to understand the role played by the Insurers' Advisory Organization before making any recommendations in respect of rate regulation. The Insurers' Advisory Organization (IAO) is the largest insurance advisory rate-making body in Canada.

The IAO comprises over 50 member company groups who write property and casualty insurance in Canada; since April 1985, its services have been available to members on a "user-pay" basis. Prior to that time, its services were only available to members who paid an annual assessment, regardless of the extent to which they used the service. IAO-promulgated rates are "advisory" only and members are under no compulsion to use them. The rates are "advisory" in nature to avoid, among other things, difficulties with the federal *Combines Investigation Act*. In actual fact, very few companies utilized IAO rates in 1985 for automobile insurance (see Table 1 in the research paper prepared for the Task Force by Woods, Gordon entitled "The Distribution System").

The IAO recommends rates for automobile insurance in Canada in all jurisdictions which are not serviced by public insurers, and for personal and commercial property country-wide. The IAO does not make rates for commercial liability because no credible statistics exist on which to begin the process. The "Red Book" generated by the IBC's statistical reporting service has been generally regarded as less than adequate.

Accordingly, the IAO advisory rate-making service is used by many insurers as the base for automobile and personal and commercial property rates from which they can create their own rates utilizing their own estimated loss experience and operating cost profile. For others, IAO rates are used as a benchmark, for comparative purposes, against which to test their own forecasts about rates. For other specialized classes of insurance or for unusual risks, insurers create their own rates based upon their own experience, underwriting criteria and operating cost profile.

Assuming the desirability of greater stability of insurance rates, particularly in light of the "yo-yo" pattern of recent years, there are several options available to improve the monitoring of the effectiveness of competition in insurance markets and thereby ensure that the consumer obtains the "best" price and insurance product possible. These include rigid rate regulation, prior approval of rate changes, and open competition rate regulation (no filing required).

There are inherent dangers in establishing a process of rate regulation:

- It may tend to favour the regulated industry. Insurer interests, with their more concentrated stakes, will have greater incentives to mobilize and greater access to relevant information and will disadvantage the less-informed consumer interest. This may result in rates being set too high.

- On the other hand, rates that are set too low can drive capital from the industry. For example, a few concentrated consumer interests might force rates to be held to below normal rates of return, with a resulting shift of capital out of the industry, a decline in capacity, and ensuing shortages in supply.

- While rates of return may be set just right, they can also fail to provide incentives to increase productivity.

Rate regulation has been tried, in its various forms, in the United States with respect to insurance rates. The opinion is that the effects have been largely cosmetic, in that regulators allow deviations from established levels in rates that are, in effect, determined by competitive forces.

In its 1979 report, the Select Committee considered and opted for open competition rate regulation (no filing required) for monitoring the effectiveness of competition. It recommended that the Superintendent require reporting of data that would satisfy the monitoring tests developed in the United States by the National Association of Insurance Commissioners (NAIC) with respect to performance indicators, structural indicators and conduct tests. (Performance indicators include the components mentioned earlier with respect to suggested improvements in financial reporting, together with information on variations in rates and price changes per company per year. Structural indicators include concentration ratios by line, market share ranking by line, and information on entries and exits. Conduct tests are less precise, but would focus on the relevant practices of the insurer in question, issues of integrity, avoidance of conflicts of interest and so forth.)

The Task Force has concluded that the option of rigid rate regulation is not a desirable direction for government action. Equally, despite the apparent success of such rate boards as the one in Alberta, the evidence is unclear as to whether the presence of a rate board is really a material factor in the increased rate stability in Alberta compared to other jurisdictions.

The Task Force has concluded, however, that the Government should strongly considering implementing a systematic framework for the monitoring, surveillance and evaluation of rates. Such regulation does not entail setting floors or ceilings on rules. But insofar as it involves a much more systematic public analysis of the underlying determinants of rates, it would certainly result in much more rate stability than we have witnessed to date. The Task Force therefore recommends that:

D.30 The Government of Ontario should seriously consider the implementation of a systematic framework for the monitoring, surveillance and evaluation of rates with a view to ensuring greater rate stability and public understanding of the determinants of rates and the basis for the rate changes.

In conjunction with the implementation of such a framework, it is also recommended that the Superintendent submit an annual report to the Ontario Legislature that would include a review of the competitive indicators monitored by the Superintendent, and a critical commentary on the analyses related to the statistical information. This too was recommended by the Select Committee in 1979 and would involve amendments to Sections 18 and 90 of the *Insurance Act*.

The concept has been implemented in Quebec in the form of the annual report of the Inspecteur des Institutions Financières. Although some argue that the comments therein on the propriety of rates come "too little, too late", no one doubts that the annual report is a useful innovation. Most recently the Dupré Report has likewise concluded that the tabling of the Superintendent's report with a standing committee of the Legislature is highly desirable, and would be an important component of any package of reforms aimed at improving the public's confidence in the financial system. The Task Force therefore recommends that:

D.31 The Superintendent of Insurance should be required to file an annual report to the Legislature forthwith after the end of a calendar year but not later than April 30, providing disclosure of the loss and expense data and a review of the competitive indicators monitored by his office.

It should be noted that, in respect of automobile insurance, as noted in Part C, the Task Force does favour greater supervision of the rates established by the Facility Association, particularly as to classification of risks and surcharges.

The Task Force does not recommend the proclamation of sections 369 to 371 of the *Insurance Act* at this time. These provisions would give the Superintendent very wide powers of regulation which do not appear to be necessary and are not appropriate in the context of the introduction of monitoring, surveillance and evaluation of rates.

V SUPERVISION OF INSURERS

Introduction

As noted above in "Financial Regulation", a number of recent reports have focused attention on the important goal of enacting more rigorous controls on the financial activities of property and casualty insurers (as well as those of other financial institutions). These reports also reflect other principal concerns of both supervisory authorities and insurers, including:

- supervisory powers with respect to troubled companies;
- modernization of the corporate governance statutory provisions; and
- strengthening of the supervisory system in general.

The Task Force agrees with the overall need for change in the very near future in order that supervisory authorities will have the proper support and powers to enable them to carry out their duties adequately and that insurers will have the opportunity to function within the checks and balances of modern-day corporate law.

Immediate Needs

Cease and Desist Orders

The Ontario *Insurance Act* authorizes the Superintendent of Insurance to issue cease and desist orders to prohibit certain unfair and deceptive practices. The *Insurance Act* does not authorize the Superintendent to issue such orders with respect to corporate practices or with respect to an insurer's financial activities. Further, the *Insurance Act* does not authorize the Superintendent to issue orders to compel a company to take specific courses of action (other than making good a deficiency of assets). The remedial powers of the Superintendent and the Minister are confined to suspending or revoking a company's licence in certain circumstances, or taking control of the assets of a company in certain circumstances. The federal Superintendent's powers are similarly limited under federal legislation.

The federal Superintendent of Insurance has recommended that the federal legislation be amended to give specific authority to the Superintendent to direct a registered insurance company to *cease* doing any act or pursuing any course of conduct that might reasonably be expected to prejudice or adversely affect the interests of policyholders of the company or to result in the company being in violation of its governing legislation. The federal Superintendent has also recommended that supervisory authorities be authorized to direct a company to take specific courses of *action* that appear necessary to protect the assets of the company or their value, to ensure that the company carries on its business in a sound, businesslike manner, and generally to safeguard the interests of policyholders.

It is essential that the Superintendent be authorized to take action without prior notice to the company in circumstances where the vital interests of policyholders or the public may be prejudiced by the delay involved in a notice procedure. The Task Force agrees that the supervisory authorities should have such powers and the Task Force therefore recommends that:

D.32 The insurance legislation of Canada and Ontario should be amended to authorize the respective Superintendents of Insurance to issue orders requiring a registered or licensed insurance company to

a) cease doing any act or pursuing any course of conduct that might reasonably be expected to prejudice or adversely affect the interests of policyholders of the company or to result in the company being in violation of its governing legislation; and

b) take specific courses of action that appear necessary to protect the assets of the company or their value, to ensure that the company carries on its business in a sound, businesslike manner and generally to safeguard the interests of policyholders,

and that, in particular, the Superintendent be authorized to proceed without prior notice to the company in circumstances where the vital interests of policyholders or the public may be prejudiced by delay.

Role in Administering Companies in Difficulty

There generally is an interregnum between the time when a Superintendent of Insurance takes control of the assets of a company and the time when it is decided whether the company can be rehabilitated or must be wound up. The Superintendent may be placed in a difficult position during this phase.

The Superintendent may be reluctant to maintain "business as usual" until it is known for certain whether the company can be rehabilitated. This may tend to make rehabilitation more difficult and wind-up more likely. Until a compensation fund or funds are established the Superintendents will continue to be placed in a difficult position. The Task Force has already recommended elsewhere in this Report the creation of a compensation fund.

Structures for the Future

Corporate Governance

Both the Green Paper and the Blenkarn Report have made extensive recommendations with respect to the modernization of corporate governance. The Insurance Bureau of Canada agrees on the need to bring insurance legislation into line with modern approaches to corporate law generally and sound business practices for financial institutions in particular. The Task Force therefore recommends that:

> **D.33 Federal and provincial authorities should accord immediate priority to revision of insurance legislation to bring it into line with modern approaches to corporate law generally and sound business practices for insurance companies in particular, and resulting legislative amendments should include a provision requiring regular review of the legislation governing insurance companies.**

Supervisory System

The Green Paper, Blenkarn Report and Dupré Report all favour a greater centralization of supervision for financial institutions. The Dupré Report recommends that this occur separately at the provincial level, while the Green Paper proposes an amalgamation of the federal regulatory agencies. The Blenkarn Report, taking a broader approach to this issue, recommends the establishment of a National Financial Administration Agency (NFAA) that would include both federal and provincial participation along with private sector participation. This agency would be national in scope and involve both supervisory and policy responsibilities.

Under each of the federal proposals, the regulatory agencies would be responsible for all financial institutions, with a separate branch for, *inter alia*, general insurance companies. The Blenkarn Report and the Dupré Report recommend that all regulatory costs be charged back to the supervised institutions.

The Green Paper and the Dupré Report recommend federal-provincial mechanisms to harmonize policies and implementation, whereas the Blenkarn Report would involve joint federal- , provincial- , and private-sector control of the agency, which would set common standards and assure consistent enforcement. In the Task Force's view, the Blenkarn Report recommendations should be viewed as the ultimate goal for the Canadian regulatory system. The Task Force recognizes, however, that at this point both the federal and provincial governments appear reluctant to transfer their authority and responsibilities (particularly for policy) to such an independent agency.

As a result, it is likely that separate federal and provincial regulatory structures will remain in place with centralization of the agencies occuring in both jurisdictions. Unfortunately, this also removes the prospect of greater self-regulation that was proposed in the NFAA concept since the private sector will not participate, under those proposals, in the operations of the agency.

The Task Force therefore recommends that:

> **D.34 The federal, provincial and territorial governments should immediately establish a Council of Ministers Responsible for Financial Institutions to consider in advance all matters pertaining to the policies and regulatory practices governing financial institutions, including property and casualty insurance companies.**

VI TAXATION

Introduction

Though taxation affects risk and insurance in many ways, four matters of special interest turned up in the work of the Task Force. The first is the personal income tax on claims paid to individuals, particularly compensation for bodily injury. The second concerns the treatment of reserves held by taxpaying financial and non-financial producers of goods and services which self-insure part or all of the risks to which they are exposed. The third is captive insurance companies. The fourth is the tax treatment of stabilization reserves and reserves against future shock losses by insurers.

The general nature of the tax treatment of premium payments and claims receipts in property and casualty insurance must be understood before considering these tax issues. Citizens as householders, car owners, etc., pay insurance premiums which are not deductible; i.e., they are paid out of after-tax dollars. Claims paid under such policies are not taxable. Similarly, if someone purchases an income replacement policy or a disability income policy, the premiums are not deductible and any payments under the policy are not taxable.

If, as a result of a personal injury, a person recovers, as a third party under someone else's policy, a lump sum payment representing loss of future income, the lump sum is not taxable. Income earned on the lump sum is taxable, as is the interest element of an annuity purchased with the lump sum. If, however, the lump sum is paid out in the form of a structured settlement, none of the monies is taxable.

Claims paid on account of additional costs of care that have arisen from an injury are not income; they are compensation for costs that would not otherwise have been incurred. However, in certain circumstances a part of claims paid to persons under this heading has been subject to personal income tax in Canada — wrongly, as the Task Force argues below. Claims paid for rehabilitation and miscellaneous special help required by the injury likewise are not income and should not be treated as taxable income: they are usually excluded.

What about compensation for non-economic losses; payments as compensation for pain and suffering of the victim, or payment to family members of a person injured or killed for the loss of care, comfort and companionship? Lump sum payments of such compensation have not been treated as taxable income, though income from the investment of that capital would be taxable in future years.

The tax treatment of the non-personal insured is, with some exceptions discussed below, straightforward and proper. Businesses generally treat premium payments to insurers as expenses in reckoning their taxable income, and this is normally accepted by the tax authorities. If a business suffers a loss and receives compensation from an insurer, the loss is partly or fully offset by the payment from the insurer. The receipt only affects the net capital and surplus position of the insured, and enters into the tax treatment of business income and capital gains in the ordinary way.

Compensation for Future Care Costs

The first of the serious taxation issues which the Task Force confronted was the tax treatment of lump sum payments for the economic *losses* associated with the costs of future care of injured persons. This is the famous "gross-up" issue. If a lump sum award or settlement is made to meet the costs of future care, the revenue from the lump sum for a number of years after the award will exceed the actual and possibly deductible costs of care. If the actuarial expectations on which the lump sum was calculated, before taxes, are precisely fulfilled, the excess of income in the early years will exactly balance off the deficiency in the later years. The injured will start with no capital and end with no capital. However strange it may seem, under the personal income tax system the excess of revenue over costs of care in the early years is taxed as income. However, in the later years, when the costs of care exceed the revenue from the then diminished capital sum, equivalent amounts are not given back from the consolidated revenue fund.

The Task Force considers this practice to be a fundamentally improper taxation of awards and settlements for the costs of future care. The fundamentals are argued in Appendix 20. The tax authorities acknowledge, though they have not legislated on the matter, that costs for care of an injured person are compensation for an economic loss, and not income. If the stream of future costs on this account is matched by a structured settlement which provides a matching stream of payments, then no part of such payments is regarded as income for taxation purposes. If a lump sum is paid in lieu of a stream of future revenue to meet these anticipated costs, the injured person under normal actuarial expectations has no net increment of wealth or net increment of income over the life of the settlement. Therefore there is no net income and there should be no net income tax. In fairness, if the tax authorities tax a part of the revenue in the early years, they should furnish refundable, transferrable tax credits which can be exercised in the later years. This would be far too cumbersome and open to abuse. The Task Force therefore recommends that:

D.35 The taxation of revenue from lump sum settlements which arise as compensation for the economic losses of injured persons under the heading of costs of future care should be abolished. This would eliminate gross-up with respect to the costs of future care.

D.36 The practice of exempting structured settlements for compensation for the economic losses of injured persons under the heading of costs of future care should be continued and codified.

Self-Funded Reserves

The second issue concerns the taxation of self-funded reserves. Self-insurance is becoming more common. The Task Force is of the view that companies which opt to self-insure should be given incentives to accumulate reserves against future losses. The current taxation of such reserves, however, operates as a serious disincentive.

The Task Force recommends a change in tax laws to allow corporations to take tax deductions on "self-funded" reserves in the same way that an insurance company can on its claims reserves. This would encourage large corporations to retain more responsibility for their own risks. Such a change would be beneficial, provided that the amount of risk retained is compatible with the risk-bearing capacity of the corporation (or other business entity). Three important benefits accruing from this would be:

(1) More insurance capacity would be freed up for those smaller business entities and/or individuals whose lower risk-bearing capacity renders them more dependent on insurance.

(2) More insurance capacity would be freed up for new types of coverage needed to respond to our changing environment and for catastrophe coverage.

(3) Greater levels of risk retention would, at least in the long run, lead to greater attention to loss prevention and control, which would benefit both the individual corporations and society as a whole.

Self-retention of these risks would eventually become a viable proposition for many larger corporations if they were able to set aside reserves, on a tax-deductible basis, in years when their losses were lower than the average for the period as a whole, in order to fund for those inevitable years when losses will be much greater than average. This is similar to what would be referred to in certain areas as a "claims stabilization" reserve and would increase the ability of firms to self-retain their own risks and thus increase the extent to which the benefits identified above could accrue.

This could have long-term benefits for society: it would be clearly beneficial if companies with a high pollution liability exposure were able — or even required — to set aside, in a trust fund, sums of money to cover the costs they will eventually have to pay for the damage they are causing to the environment.

The Task Force recognizes that certain controls would have to be placed on such reserves, including:

(1) If reserves set aside for losses not yet paid are to be tax deductible, strict controls will be required to avoid abuse.

(2) If corporations are to be encouraged to retain greater amounts of their own risk themselves, high standards of professional advice on the extent to which this is appropriate will be required.

(3) To prevent abuse, some form of trust might have to be created for tax-deductible reserves.

The Task Force recommends that:

D.37 The tax laws should be changed to allow corporations to take deductions on self-funded reserves in the same way that an insurance company can on its claims reserves, subject to appropriate controls to avoid abuse.

Captive Insurers

In certain circumstances and with proper regulation, it is socially desirable to allow operating companies to make use of captive property and casualty insurance organizations. Under existing legislation and regulations, the use of captives has not been optimal. Moreover, because of tax considerations, most captives that have been used have been offshore captives, frequently based in tax havens such as Bermuda and the Bahamas. If captives are to be used, there is merit in their being domestic, openly and properly integrated into the Canadian insurance scene, and subject to the regulation of Canadian authorities. In the United States, some states have encouraged the domestic domicile of insurance captives. The regulatory aspects of captives have already been considered in this Report. In addition, the Task Force recommends that:

D.38 The tax treatment of captive insurance companies should be examined, alongside the regulatory aspects of such captives, with a view to promoting the domestic domicile of such captive property and casualty insurance companies as are considered to be an appropriate part of the Canadian property and casualty insurance markets.

Reserves (Stabilization and Major Shock Losses)

Finally, two tax matters related to the reserves of property and casualty insurers have come to the attention of the Task Force: insurer stabilization reserves and insurer contingency reserves for large shock losses. Historically, property and casualty insurers have not explicitly recognized a "premium deficiency" on their balance sheet; yet they have recognized such deficiencies in their internal rating and planning procedures. Although some companies already include premium deficiency reserves on their balance sheets, regulatory plans to require actuarial certification will force recognition of this item. The tax authorities, administratively, have allowed such provision of reserves as an item in reckoning taxable income in recent years, but confirmation would be helpful.

The logic of such a practice is essentially the same as the provision by banks of reserves against bad and doubtful loans. The allowance of such reserves to property and casualty insurers would have to be subject to rules to prevent abuse, just as bank reserves are. The Task Force therefore recommends that:

D.39 Property and casualty insurers should develop, with the tax authorities, a set of rules for the deduction of premium deficiency reserves where an insurer has a

premium deficiency reserve program and includes such reserves on its balance sheet, and provision should be made for rules regarding additions to such reserves as an expense item for the measurement of the taxable income of the insurers.

The other reserve and tax item regarding insurers concerns reserves for shock losses, such as the periodic wiping out of greenhouses, or other disasters. It has been recommended to the Task Force that property and casualty insurers be allowed to set aside a small proportion of premium income into a reserve against major shock losses and that such charges to reserves be an expense in reckoning taxable income. The Task Force therefore recommends that:

D.40 The industry, the regulatory authorities and the tax authorities should explore means of improving the provision and use of reserves against major shock losses, related particularly to disasters due to natural causes, including the taxation treatment of such reserves.

VII A MORE ACTIVIST ROLE FOR GOVERNMENTS IN PROPERTY AND CASUALTY INSURANCE

Introduction

In addition to setting frameworks for, and regulating the operations of, private property and casualty insurers, governments all over the world take a somewhat more activist role from time to time. They lead, persuade, threaten, order and encourage the market operators to form pools and provide various services on different terms – sometimes, but not always, with some government backup. They become residual insurers for particular risks or in special circumstances. They provide insurance services when there are extreme uncertainties, such as those arising from earthquakes, terrorism, floods, crime or war damage (and in Ontario, crop failures) when even very strong private markets cannot cope adequately. They may become the main deliverers of some insurance services through a government monopoly insurance operation or in competition with private insurers (see List A attached at the end of Part D).

Canada has some or all of these activist experiences of governments in property and casualty insurance. The Ontario government has been more than a passive co-operator or regulator in the development of the Facility Association, the Spills Pool and the Ontario Liability Insurers' Pool. The federal government has continuously been involved for decades with export insurance for difficult overseas trade risks (including sovereign risks) and export credits. The Ontario government has residual responsibilities regarding greenhouses, pollution and environmental risks. Four provinces operate government insurance corporations. The Task Force has been asked to make recommendations on a government insurance corporation for Ontario.

In this Part, the initial examination is of government insurance corporations because the establishment of such a corporation in Ontario would be the largest institutional change anyone has yet suggested in the delivery of property and casualty insurance. Next, more piecemeal options for government acceptance of risks and delivery of some or occasional insurance services will be considered. Finally, the important roles of government as animators in insurance services will be addressed.

The most important general message of this Part of the Report is that, if the private insurance institutions (which include mutuals, pools, co-operatives, joint-stock companies, and individual proprietorships and partnerships) perform insurance services inadequately from a social point of view, inefficiently and with a high degree of uncertainty and instability, then governments, and in particular the Government of Ontario, will inevitably be drawn into more activist roles for at least some property and casualty insurance services.

Government Insurance Corporations

Canada is one of the 16 countries in which there are stable government insurance companies that are in competition to some extent with private sector insurers. They are the following:

> **Saskatchewan Government Insurance:** monopoly supplier of the compulsory portion of automobile insurance and a competitive supplier of optional automobile insurance and of general insurance.
>
> **Manitoba Public Insurance Corporation:** monopoly supplier of the compulsory portion of automobile insurance and a competitive supplier of the optional part of automobile insurance and other general insurance.
>
> **Insurance Corporation of British Columbia:** monopoly supplier of the compulsory portion of automobile insurance and a competitive supplier of other automobile insurance; no longer a supplier of general insurance.
>
> **La Régie de l'assurance automobile du Québec:** monopoly supplier of the compulsory bodily injury benefits associated with the use of automobiles.

The Task Force has reviewed the documentation on these corporations and engaged in direct discussions with each of them, and the Chairman of the Task Force has prepared a personal report that is of greatest relevance to the consideration of a government insurance corporation in Ontario. This is included in the Report as Appendix 19.

In order to consider clearly the merits of establishing a government insurance corporation in Ontario, some misinformation and confusion have to be cleared up at the outset. The most important is the distinction between the design or content of the insurance services that are desired in Ontario and the means of providing the services. Most of the discussion concerns auto insurance; we shall initially concentrate on that domain, but later consider other risks and insurance services.

The design of an auto insurance system and the means of delivering the system are very largely separate issues. Many people would like to have an improved set of no-fault accident benefits relating to bodily injury in the Ontario system. There is no need to have a government insurance corporation to accomplish such a change in the design of the insurance services. Many people would like to see a rating system for auto users based on driving and accident experience, rather than on age, sex and marital status. Lower insurance premiums for young unmarried men with good driving records is the desire of many people. There is no need to have a government insurance corporation to accomplish such a change in the design of the insurance services. Many people would like to have some improvements in the distribution system and in the information system. Again there is no need to have a government insurance corporation to accomplish such an improvement. The central question is whether, for the same basic design of auto insurance services, a private system, such as exists and can evolve in Ontario, can deliver the product more efficiently, with less difficulty and frustration, with lower transactions and legal costs, and with greater responsiveness to the diverse tastes of the public than a government corporation.

The Chairman considers the following to be a fair-minded evaluation of the facts. **First,** when the government insurance companies in Canada have been well run and not overburdened by social missions and unreasonable restraint on their premium rates by their masters, they have been quite efficient. They have all been efficient performers in recent years. They have also managed to achieve a few social goals as well as provide good-quality insurance services.

Second, when comparisons have been made, as best one can, on the basis of "apples with apples", they have shown that in recent years government insurance companies have managed to put a little more of the revenue dollar into claims payments than on average private insurers have in Ontario.

Third, the advantage is not much. Some companies in Ontario are very efficient by any standard. The good performance of the government corporation may well be temporary as the signs of increased litigiousness have appeared in the western provinces, all of which operate with a mixture of no-fault and tort compensation schemes. The combination of contingent fee lawsuits and the advertising of legal services in British Columbia especially raises worries about the cost trends of insurance in that province.

Fourth, the government insurance corporations do appear to reduce the choice open to the citizens and the competition in service to customers.

Fifth, all of the government insurance corporations have had at least one period of unsatisfactory performance, even in automobile insurance. All of them have had more frequent and serious difficulties in general insurance, with the possible exception of the Insurance Corporation of British Columbia.

Sixth, the data and analytical systems in the government insurance corporations have been impressively efficient, using state-of-the-art technology. This is especially true of the Insurance Corporation of British Columbia. Such systems have been a major factor in the relatively good performance of these corporations in the recent insurance cycle.

Seventh, this has to some extent been offset by the losses experienced by both the Manitoba and Saskatchewan corporations in reinsurance in recent years.

Finally, compulsory auto insurance and personal lines property insurance, which have been the staples of the government insurance corporations, are not the centre of the greatest problems in property and casualty insurance in the 1980s in any case. And even the important automobile insurance questions are about design, not delivery mechanisms. Thus government insurance corporations deliver the *existing design* of automobile insurance, and *compensation* does not appear to be the top priority for a (perhaps necessary) activist role of governments in of property and casualty insurance.

In view of these evaluations the Task Force recommends that:

D.41 The Government of Ontario should NOT establish at this time a government insurance corporation to deliver auto insurance services.

D.42 The Government of Ontario should concentrate its efforts regarding auto insurance on improvements in the design of the system set out in Part C, which it is contemplated will be delivered by an evolving private insurance market system.

D.43 If the Government of Ontario does choose, for a balance of political and social reasons, to establish a government insurance corporation to deliver auto insurance services, it should take steps as indicated in the Chairman's memorandum to try to ensure a "good-performing" rather than a "poor-performing" government corporation. This is not a simple or easy task.

Two other general considerations also bear on the establishment of a government auto insurance corporation in Ontario. Governments have limited political capital and energy. Some selection of more important subjects for their efforts is highly desirable. The Chairman of the Task Force suggests that there are more important insurance issues than government delivery of auto insurance that require attention.

The other consideration arises from the fact that Ontario is, more than any other province, the centre of the nation's capital markets and financial services. The consequences of nationalization or provincialization of much of the property and casualty insurance industry in Ontario for the overall attractiveness and effectiveness of the broader financial functions should be considered.

These recommendations do not imply a laissez-faire approval by the Governments of Canada and Ontario to a number of enduring structural issues of property and casualty insurance, to which we now turn.

Activist Roles for Governments with Respect to Structural Problems

Governments as Animators in the Property and Casualty Insurance Market

The role of government as an animator regarding general insurance can be distinguished from its roles as a regulator, a marginal or fringe participant in delivery systems and a mainline deliverer of services. As animator, government is mainly assisting the private institutions and participants in market processes. Operating market assistance programs and information hot-lines, assembling and informing interested parties, providing a little "tender loving care" to new institutions in their formative stages, promoting improved data and analytical systems — these are the kinds of activities comprising animation.

Regarding animation, some historical perspective is important. Governments of all ideological stripes in virtually all parts of North America, Western Europe, Japan and the Commonwealth have played some animation role in general insurance for many decades. Animation is not a recent or hypothetical or especially Ontario affair. However, for the Task Force it is Ontario's experience and possibilities that are of primary concern.

What are the fundamental bases for governmental animation activities in relationship to general insurance? Why do governments intervene or feel they have to intervene to "help" the private markets? The answers are on two levels: one, broadly political or social; and the other, operational.

If governments are going to impose mandatory insurance requirements on segments or activities under their jurisdictions (e.g., compulsory automobile insurance, compulsory liability insurance as a licence condition for professional practice), then governments have to ensure that the service is available, even if in some circumstances private markets have difficulty providing the service. Animation may be required to overcome some of the reluctance of a private market to provide the full range of required services to all the participants who are subject to the requirement.

Still, on the broadly political or social level, general insurance services are so pervasive and vital to so many people, quite apart from standards imposed by governments, that governments cannot be expected to stand idly by if groups in society have difficulties with the availability, price, affordability and accessibility of insurance. Society expects and demands help, at least of an animatory kind.

On an operational level, three considerations underlie government intervention, even if only of the animation type. First, a private market arrangement, all on its own, may have real difficulty in internalizing the costs and benefits of some activities. The activities would not be done or done adequately without some collective action being organized. Second, there may be severe obstacles to collective action by the private players, arising from legislation or rules or fear of allegation of cartel activities, or other activities in restraint of trade. Government animation may overcome this problem. Third, there may be disincentives for change resulting from structure or patterns of behaviour that are too entrenched to be changed by the private players themselves.

Virtually all reasonably developed countries have social security insurance. The major exceptions are Moslem countries, where of course Islamic law requires that the family care for the aged and sick. In addition, all developed industrial countries have export credit guarantee insurance provided by governments. Some countries, such as Brazil, require primary insurers to place their business with a government reinsurer (see List B attached at the end of Part D). Presumably, these countries are attempting to keep funds within their jurisdiction, rather than provide extra capacity.

The most important feature of our study concerns special catastrophe insurance that is provided by governments. This insurance is prevalent among developed countries, which do not necessarily have socialist regimes. Examples are contained in List B. In studying List B, one is struck by the following features:

(1) Each of the perils insured against is indeed one that is naturally associated with that country (e.g., Japan, earthquakes).

(2) The insurance is provided, not on grounds of politics, but on grounds of need.

(3) Insurance is not particularly widespread.

The special risks to which the province of Ontario is prone should also be considered in the light of these special catastrophe insurances provided by other governments. It would seem reasonable to assume that:

(1) Ontario is one of the jurisdictions in the world most reliant on exports; and

(2) Ontario exports into the most litigious country in the world (i.e., the United States).

These two features combined are, it seems, special to Ontario. Thus, some form of export liability insurance should be seriously examined by the Ontario government. Such a program would encourage exports by Ontario manufacturers and service industries, provide a cutting edge in competing with American manufacturers and reduce the overall exposures for most Ontario businesses.

The other enduring structural problems of liability insurance in Ontario which have been identified to the Task Force (and reported earlier and in Appendix 18) include pollution and environmental risks, the services of the province and its creatures (municipalities, school boards, utility boards, etc.), professional services and services of volunteers. For many of these the industry alone may not be able to cope effectively in the next few years.

Accordingly the Task Force therefore recommends that:

D.44 The Government of Ontario should consider a more activist role in insurance and reinsurance, in association with the industry, to meet the difficult structural problems of uninsurable risks and uncertainty, particularly as regards product liability (especially in relation to exports to the United States), pollution and environmental risks, the services of the province and of its creatures, professional services and voluntary activities. Some of these problems appear to be enduring rather than transitory, and a government insurance corporation may well be an appropriate vehicle for helping to deal with these problems.

The Government of Ontario has been active as an animator in insurance markets, particularly during the last year. In this Report, the Task Force reviewed the government's role in promoting the development of the Facility Association, the Spills Pool, the market assistance programs and the Ontario Liability Insurers' Pool; encouraging and assisting the development of new pools, reciprocals and mutuals; promoting the Canadian Insurance Exchange; developing a compensation fund; and improving the data systems and analysis. The federal and Ontario governments have been involved in helping the industry to solve problems for general insurance companies that had difficulties.

These activities appear to be meritorious, and a number of them appear to have been rather well done under difficult circumstances. The Task Force appreciates how difficult the problems of balance and continuing involvement are in such activities. Neither the government nor the industry wants to stifle the development of ongoing private sector developments. Yet the very fact of government involvement permits the public and the industry to pass their more difficult problems over to government. Once the government is providing a service, it may be hard to stop providing it.

LIST A

Forms of Insurance Provided by Canadian Governments

(excludes health insurance)

A. **Automobile**
Quebec — third party only
Manitoba
Saskatchewan
British Columbia

B. **Export Credit Guarantee**
Federal

C. **Mortgage Guarantee Insurance**
Federal — CMHC
In competition with the Mortgage Insurance Company of Canada.

E. **Property**
Manitoba
Saskatchewan

E. **Workers' Compensation**
All provinces, but not the Yukon or the Northwest Territories, where it is provided by the private sector.

F. **Crop Insurance**
See, for instance: *Crop Insurance Act*, R.S.O. 1980, c. 104.

LIST B

Forms of Insurance Provided by Governments

A. **Insurance Virtually Totally Controlled by Government**
All Eastern Bloc Countries
Columbia
Nigeria
Pakistan (life insurance only)
Peru

B. Well-Developed Social Security Insurance Systems

Virtually all countries except

- Brazil
- Chile
- Hong Kong
- Indonesia
- Republic of Korea
- Morocco
- Pakistan
- Saudi Arabia
- Singapore
- Republic of South Africa
- Taiwan
- Turkey

C. Competing State Companies (to Some Degree)

- Australia
- Canada
- France
- Ghana
- Greece
- Indonesia
- Mexico
- New Zealand
- Pakistan
- Portugal
- Spain
- Switzerland

D. Compulsory Life Insurance for Civil Servants

- Argentina
- Philippines
- Taiwan

E. Compulsory Reinsurance with a Government Reinsurer

- Brazil
- Ghana
- Kenya
- Malaysia
- Morocco

F. Catastrophe Insurance Provided By Governments

Iceland — all catastrophes
Israel — war damage
Japan — earthquake
New Zealand — earthquake or war
Philippines — crop failure
Republic of South Africa — riot and malicious damage
United States of America — flood and crime

G. Export Credit Guarantee Provided by Governments

Austria
Bahamas
Belgium
Canada
Cyprus
Denmark
France
Hong Kong
Iceland
India
Ireland
Israel
Italy
Japan
Luxembourg
Malaysia
Norway
Republic of South Africa
Sweden
Switzerland
United Kingdom
West Germany

NOTES — PART D

[1] See Cassels, Brock & Blackwell, "Ontario and Canada: Overview of Regulation of Insurance" (April 1986) in Appendix 9.

[2] The concept of "public interest" is a difficult one. As pointed out in a paper prepared for the Task Force: "It appears that the 'public interest' as a concept does not have any clear substantive content; it can more usefully be understood as a characterization of the debate about the definition and weighing of various interests. It implies achieving a just balance among all the relevant interests, and a policy consistent with generally accepted principles fundamental to our economic, political, legal, and administrative systems — principles such as efficiency, accountability, fairness and practicality." See Carolyn Tuohy and Marsha Chandler, "The Role of Government in the Insurance Arena in Ontario: A Political Analysis" (April 1986).

[1] Id.
[2] Id.

[1] Vennell, "Problems of New Zealand's No-Fault Accident Compensation Scheme", (1984), New South Wales Law Society Law Journal 44, p. 47.

[1] Hodge, "No-Fault in New Zealand: It Works" (1983), Ins. Conn. Jo. 222, p. 230.
[2] Ison, Accident Compensation: A Commentary on the New Zealand Scheme (1980), p. 187.
[3] Vennell, op. cit, p. 45.

SUMMARY
OF
RECOMMENDATIONS

SUMMARY OF RECOMMENDATIONS

PART B: THE CRISIS IN LIABILITY INSURANCE

RESPONSES TO THE CRISIS AND PROPOSALS FOR REFORM

Claims-Made Policies

B.1 The industry should take immediate steps to ensure clear and timely explanations of the scope and application of the claims-made policy are provided to insureds directly, and through brokers and agents.

B.2 The Superintendent of Insurance should be accorded wider powers of regulation in respect of the approval of commercial general liability policy forms, with a view to imposing minimum standards and to preventing potential abuse of the claims-made form by insurers.

B.3 The Government of Ontario should undertake a review of all statutes requiring minimum commercial general liability insurance coverage to determine if any additional provisions are required in the case of a claims-made policy form, such as mandatory tail coverage.

B.4 Specific attention should be given to the claims-made policy form in establishing regulations with respect to minimum notice periods for non-renewals of coverage, mid-term cancellations and changes in coverage. (See Recommendation D-29.)

Environmental Impairment and Pollution Exclusions

B.5 Consideration should be given to requiring the companies engaged in environmentally hazardous activities to set aside reserves to cover potentially catastrophic pollution events. Such reserves should be tax-exempt (see also Recommendation D.37).

B.6 The Government of Ontario should take steps to encourage the formation of an industry-based pool to accommodate currently uninsurable risks such as leaks from underground storage tanks involving fuel at service stations, home heating and oil, and industrial storage of fuel and other raw material and products.

B.7 The *Insurance Act* should be amended to make clear that insureds such as oil companies are permitted to indemnify members of their sales associate network and other non-affiliated companies and contractors in the event they suffer losses for which insurance protection is either unavailable or prohibitively expensive, such as coverage for underground tank leaks and other pollution-related exposures.

B.8 The Superintendent of Insurance should work with the insurance industry to develop adequate provision for "sudden and accidental" pollution coverage within the Commercial General Liability policy, and if necessary, address the problem by way of minimum statutory conditions.

Legal Defence Costs

B.9 The Superintendent of Insurance should examine the treatment of defence costs under the Commercial General Liability policy and, if necessary and appropriate, make recommendations to the government for appropriate action to enhance the protection of the insured.

Proposals for New Facilities and Enhanced Capacity

Reciprocals

B.10 The Superintendent of Insurance should continue to encourage the establishment of reciprocal insurance exchanges in appropriate cases, and should prepare a booklet describing the nature of reciprocal exchanges, their potential advantages and the statutory requirements under the *Insurance Act*, designed more specifically for commercial entities.

B.11 The provisions of Part XIII of the *Insurance Act* should be updated and clarified with respect to the obligations of subscribers or members of reciprocal exchanges.

B.12 The Superintendent of Insurance should request a ruling from Revenue Canada on the taxation of reciprocal exchanges and make available a commentary prepared by Revenue Canada to interested persons.

Insurance Pools

B.13 The insurance industry should be encouraged to continue to adopt pooling measures as required from time to time.

B.14 The Government of Ontario should continue to be prepared to act as the facilitator of industry-based insurance pools when capacity crunches emerge from time to time.

Export Liability Insurance Pool

B.15 The Government of Ontario should give strong consideration to sponsoring an insurance industry pool, the terms of reference of which will be carefully drawn up so as to restrict assistance to those exporters experiencing a severe availability, adequacy and affordability crunch, and to avoid any appearance of subsidizing inefficient producers and manufacturers. The pool should be administered by the industry and include a hot-line service. Government financial assistance might be provided by way of reinsurance of the last resort, or guarantor of retrospective rates and excess losses when the capacity even within the pool proves inadequate and where the situation so demands in accordance with prearranged guidelines.

New Mutuals

B.16 The Superintendent of Insurance should ensure that greater information on the possibility of creating mutual or cash mutual insurance corporations, as viable mechanisms for expanding capacity, be provided to the public.

Expansion of Farm Mutuals

B.17 The proposals of the Ontario Mutual Assurance Association should be proceeded with as quickly as possible. These proposals will give farm mutuals the same investment powers as other insurers, and the ability to form subsidiaries designed to provide commercial and urban insurance coverages. Such subsidiaries should be subject to capital requirements, regulations and taxation comparable to those applying to joint-stock property and casualty insurers. At the same time, the guarantee fund of the farm mutuals must be extended to their subsidiaries to ensure adequate protection of the public.

B.18 Farm mutuals should also be required to conform to the same rules for financial reporting and disclosure as other insurers.

Extended Functions of Captive Insurers

B.19 The Government of Ontario should take steps to facilitate the formation of domestic captive insurance companies and the *Insurance Act* should be amended to extend to such captive insurers. The new provisions should permit sophisticated buyers of insurance to form their own insurance companies with a minimum of regulatory oversight.

B.20 Revenue Canada should be requested to review its position vis-à-vis captive insurers, and the federal government should be urged to make any appropriate changes to the *Income Tax Act* if necessary.

Self-Insurance

B.21 The Government of Ontario should request the federal government to amend the *Income Tax Act* to permit corporations to take tax deductions on self-funded reserves in the same way that an insurance company can on its claims reserves.

Insurance Exchange

B.22 The Government of Ontario should take immediate steps, with the support of its federal and provincial counterparts, to establish the Canadian Insurance Exchange in time to take advantage of the reinsurance treaty renewal period commencing January 1, 1987.

THE CALL FOR TORT REFORM

Some Interim Measures

B.23 The Government of Ontario should consider taking action to introduce changes in the spirit of the proposals reported above on pre-judgment interest, gross-up and structured settlements, and joint and several liability and limitations. The Government should consider the treatment of collateral benefits in connection with recommendations C.1 and C.2 for reform of the compensation for bodily injury due to auto accidents. The Government should give prompt consideration to the risk and liability problems of volunteers. The industry and the Government should seek to develop and apply arbitration as an alternative method of dispute resolution in accident compensation cases.

B.24 The Government of Ontario should develop and implement, with the co-operation of the industry, a statistical plan for the gathering of data and the analysis of awards and settlements of compensation for accidents, including the components that are used in building up overall awards or settlements.

B.25 The OLRC study should expand its mandate to include each of the eight reform areas that were discussed above. In particular, the question of joint and several liability, appropriate limitation periods, the need for Good Samaritan legislation, and the arbitration of accident benefits should be added to the OLRC personal injury study.

B.26 A parallel study should be commenced by the OLRC to address problems that go beyond the personal injury area and that relate to liability under the tort system in general, particularly in the professional liability sphere. The Task Force will ensure that the OLRC obtains a copy of the Lilly study and related briefs and papers so that such questions as concurrent liability, joint and several liability, appropriate limitation periods, incorporation by professionals and other matters raised therein can be studied in a careful and systematic way.

B.27 The work of the Ontario Law Reform Commission in both of these areas should be accelerated so that its final report can be made available as soon as possible.

THE NEED FOR A FUNDAMENTALLY DIFFERENT APPROACH TO ACCIDENT COMPENSATION

B.28 In the short term, a new accident compensation scheme should be implemented by the private insurance industry at least for automobile accident injury. (This proposal is developed in more detail in Part C.)

B.29 Ideally and as a medium-term objective, government should begin to work with the private insurance industry to design a universal accident compensation plan that would include compensation for all accidental injuries.

B.30 Eventually and in the longer term, federal and provincial governments should begin planning the co-ordination and rationalization of all existing first-party no-tort compensation schemes into a universal disability compensation program.

PART C: OTHER INSURANCE ISSUES

AUTOMOBILE INSURANCE

Options for Reform of the Automobile-Related Personal Injury Compensation System in Ontario

C.1 The Government of Ontario should work with the insurance industry to devise the framework for the private delivery of the new system of personal injury compensation recommended herein. Particular emphasis should be placed on ensuring the provision by the industry of adequate layers of first-party insurance coverage above the minimum mandatory compensation levels, as well as ensuring access to adequate rehabilitation services. In addition, the industry, with the assistance of the Government, should establish a pooling mechanism such as a catastrophic claims fund to ensure that all insurers, regardless of size, are in a position to meet their obligations to provide first-party coverage in respect of victims of catastrophic injury. The Facility Association can perhaps provide the necessary mechanism. Finally, the Government must ensure that the industry establishes adequate dispute resolution mechanisms, whether by way of expeditious arbitration or otherwise.

C.2 The Government of Ontario should then introduce a mandatory system of auto insurance for personal injury compensation whereby all insureds purchase a basic minimum level of insurance including coverage for loss of income, costs of care, and unlimited rehabilitation and medical expenses. The minimum level for loss of income should be set at a level such as to cover a clear majority of the population of Ontario, and should be subject to the appropriate cost-of-living indexation formula, and to an annual review by a committee of the Legislature. Where considered appropriate, insureds could purchase additional layers of income replacement coverage on an individual or group basis.

C.3 The Government of Ontario should consider elimination of resort to the tort/litigation system with respect to personal injury compensation from automobile accidents; or

C.4 The Government of Ontario should consider substantially limiting resort to the tort/litigation system with respect to personal injury compensation from automobile accidents, by way of a threshold.

C.5 In conjunction with the introduction of a new system of personal injury compensation, the Government of Ontario should work with the insurance industry on an urgent basis to enhance the deterrent to hazardous driving, and to implement an effective bonus-malus system for setting automobile premium rates. At the same time, the Attorneys-General of both Ontario and Canada should be strongly encouraged to continue their efforts to ensure more appropriate criminal penalties in respect of unsafe driving.

C.6 To ensure the effectiveness of the bonus-malus system, the Government of Ontario should work with the industry to devise a plan to create an integrated data base to provide drivers' claims histories, conviction records and driving experience, and explore how to make this essential information available on an on-line basis.

Automobile Rate Structure

C.7 The Superintendent of Insurance, together with his counterparts on the Canadian Council of Superintendents of Insurance, should take the necessary action to ensure that all automobile insurers in the various jurisdictions comply with the reporting requirements under the Statistical Plan as amended on January 1, 1985.

C.8 The Government of Ontario should encourage its provincial counterparts to support a uniform date between January 1, 1989, and September 1, 1989, for the implementation of the elimination of age, sex and marital status criteria. This should give the industry adequate time to collect and analyze data, and be ready to apply appropriate alternate criteria.

Rate Regulation

C.9 The *Compulsory Automobile Insurance Act* should be amended to clarify and extend the Superintendent's regulatory power to the non-compulsory component of coverage in respect of both rate levels and classifications and surcharges used by the Facility Association.

C.10 The Superintendent of Insurance should undertake immediate steps together with the insurance industry to explore the implementation of a mandatory basic classification system, at least with respect to compulsory automobile insurance, with a view to its broader application if appropriate. This would take place in conjunction with the elimination of age, sex and marital status criteria as recommended above.

Self-Insurers and the *Compulsory Automobile Insurance Act*

C.11 Municipal corporations and other public authorities in Ontario that establish, either on their own or with other municipal corporations or public authorities, an adequate plan with appropriate financial guarantees to the satisfaction of the Ministry's officials, should be entitled to apply to the Minister for the appropriate exemption from the *Compulsory Automobile Insurance Act*, and the terms of the plan, as approved, should be set forth in the exempting regulations.

PERSONAL AND COMMERCIAL PROPERTY INSURANCE AND OTHER LINES

Personal Lines

C.12 The guiding principles of the Industry/Government Committee should be reaffirmed and circulated periodically, to remind those in the insurance industry of their obligations with respect to the rejection of an application or cancellation or refusal to renew a policy because of the physical condition of the property, and indiscriminate rejection of insurance applications by reason of area should be discontinued.

C.13 The insurance industry should seriously consider, on an urgent basis, ways to provide a greater choice of options and flexibility to both the homeowners' and the tenants' package policies.

DISTRIBUTION SYSTEM

The Problem of Accessibility

C.14 The Superintendent of Insurance should monitor the situation closely and work with the Insurance Bureau of Canada, the Insurance Brokers Association of Ontario, and other relevant industry associations to ensure the development, application and enforcement of adequate guidelines to govern the broker/insurer relationship, including the orderly transfer of business from terminated agencies.

C.15 All independent brokers and captive or exclusive agents should be required to disclose to the public the extent of their capacity to sell various types of insurance products and the products of a variety of insurers.

C.16 The Superintendent of Insurance should actively encourage the insurance industry to permit and facilitate networking procedures among brokers, provided that the originating intermediaries provide much more accurate underwriting information to those in the network, and that the network be set up in such a way that insurers be approached only once with each submission. Disclosure of networking activities should be part of the procedures to protect against possible abuse of networking activities.

More Effective Communications

C.17 The Government of Ontario should assist the associations of agents and brokers to offer educational and licensing programs that meet the challenges created by the emergence of new and innovative products and services, and that improve the capacity of their members to assess the soundness of the institutions concerning whose products they advise the consumer. This recommendation was also put forward by the Dupré Task Force.

C.18 The insurance industry should be actively encouraged to pursue joint projects, such as those carried out under the aegis of the Centre for Study of Insurance Operations, much more aggressively.

Inadequate Industry Data Bases

C.19 The Superintendent of Insurance should work closely with the insurance industry, particularly the Insurance Bureau of Canada and Insurers' Advisory Organization, to improve the collection of statistics in respect of non-automobile commercial lines of insurance, and to mandate the collection of specific data and information in a similar way to that currently in place in respect of automobile statistics.

C.20 Strong consideration should be given to the establishment of a body parallel to the United States Consumer Product Safety Commission, which operates the National Electronic Injury Surveillance system (NEISS). All emergency wards of major U.S. hospitals are plugged into the NEISS system, which feeds in data on product-related injuries. In this way a much more effective statistical base and early warning system with respect to potential areas of product liability can be built up. Similar statistics on occupiers' and professional liability should also be collected and analyzed more systematically and comprehensively.

Commission Rate Structure

C.21 Insurers and brokers should consider the establishment of a sliding scale for commissions based on class and premium. Such a scale should take into account the amount of servicing required. The changes should be implemented by July 1, 1987, at the latest.

C.22 With respect to large risks, strong consideration should be given to a "fee-for-service" system as an alternative to or in combination with the present commission rate structure, bearing in mind that the acquisition costs to the intermediary, as well as the servicing, risk management and loss prevention costs, are relatively high.

C.23 All independent brokers and captive or exclusive agents should make available to customers upon request the commission schedules that apply to the various lines of property and casualty insurance which they handle.

Providing Capacity and Availability in all Areas of the Province

C.24 The Government of Ontario should strongly consider the establishment of a government-sponsored residual market mechanism to ensure the availability of adequate, affordable insurance in all parts of the province. Consideration should also be given to the establishment, in conjunction with the insurance industry, of a toll-free province-wide enquiry and placement service.

TRANSACTIONS COSTS

C.25 The Superintendent of Insurance should be directed to work with the Canadian Council of Superintendents to implement the necessary modification to the statutory financial statements to require disclosure, for publication, of segregated legal and adjustment costs, as well as the net percentage of premium dollars returned to claimants in the form of claims benefits for the immediately preceding year.

PART D: THE ROLE OF GOVERNMENT

FINANCIAL REGULATION

Who May Carry On Business as a General Insurer?

Initial and Ongoing Capital Requirements

D.1 The statutory initial minimum capitalization requirement should be increased to $5 million for new federally incorporated property and casualty insurance companies and to $3 million for Ontario-licensed property and casualty insurance companies.

D.2 Consideration should be given to the particular situation of existing small insurers, farm mutuals, new mutuals and reciprocal exchanges in implementing the minimum initial capital and surplus requirements.

D.3 The appropriate federal and Ontario legislation concerning capital and surplus margins of property and casualty insurers should be amended to provide that the ongoing capital and surplus margins would have to be at least equal to the greatest of:

(a) the existing requirements of section 103 of the *Canadian and British Insurance Companies Act*;

(b) 15% of the gross premium income of the company during the immediately preceding 12-month period plus the smaller of $500,000 or 5% of the premiums; and

(c) 22 per cent of the average annual amount of gross claims and claims adjustment expenses incurred by the company during the immediately preceding 36-month period plus the smaller of $500,000 or 7% of the said average amount;

provided that, in the case of (b) and (c), a maximum reinsurance credit of 50% is allowed for companies not limited to the business of reinsurance.

D.4 Consideration should be given to the particular situation of small insurers, farm mutuals and new mutuals in implementing the minimum continuing capital and surplus requirements.

D.5 The initial and ongoing capital requirements recommended above should be applied to each property and casualty insurer without regard to the capital of other corporations with which it may be related or affiliated.

Ownership

D.6 The federal and provincial governments should retain their current approach to foreign ownership of property and casualty insurance companies.

What financial activities can be carried on by general insurers?

D.7 Statutory and regulatory roadblocks to networking among the different types of financial institutions should be removed and appropriate statutory prohibitions on tied selling should be implemented.

Investments

D.8 The investment provisions of the legislation governing federally regulated companies and Ontario-incorporated companies should be amended to incorporate prudent management standards and the detailed quantitative, not qualitative, limits proposed in the Blenkarn Report.

Reinsurance

D.9 Each primary insurer, where appropriate, should be required, by statute or by regulation, to retain a minimum percentage of its total gross premiums written, such percentage to increase in prescribed amounts on an annual basis over a specified number of years until it reaches at least 25% of such premiums.

D.10 The federal and Ontario Superintendents of Insurance should give early priority to a reconsideration of the statutory and administrative rules or guidelines governing reinsurance provided by non-registered reinsurers with a view to increasing the degree of security maintained by non-registered reinsurers in Canada in respect of their obligations to Canadian primary insurers.

Reserves

D.11 Property and casualty insurance companies should be required as soon as possible, subject to appropriate transitional provisions, to appoint a valuation actuary and to include with their annual statement and financial statements a report by the actuary certifying that the provisions for unearned premiums and unpaid claims are adequate.

Self-Dealing

D.12 Property and casualty insurance companies should be permitted to engage in non-arm's-length transactions except those that are likely to have a significant impact on a company's solvency.

D.13 The prohibited transactions should be set forth in regulations under the appropriate federal and provincial legislation.

D.14 All property and casualty insurers should be required to pass a by-law establishing a committee of the board with responsibility for reviewing and approving all non-arm's-length transactions.

Conflicts of Interest

D.15 Property and casualty insurance companies should be required to create and maintain "Chinese walls" to prevent the flow of information between certain departments within a company or between affiliated companies where the flow of information might give rise to conflicts between: (i) the interests of customers or claimants of the company; (ii) the interests of a customer and those of the company; or (iii) the interests of a broker or agent and those of the company.

D.16 The federal and provincial regulatory authorities should consult with trade associations, professional groups, insurance companies and consumer groups in developing guidelines for increased institutional disclosure of information to consumers in view of the increased possibility of conflicts of interest arising from product bundling, corporate affiliations and networking.

Policyholder Compensation Funds

D.17 A federal policyholder compensation fund for property and casualty insurers should be established as soon as possible and membership in such a fund should be mandatory for Ontario-licensed property and casualty insurers.

D.18 If the Government of Ontario determines that a federal fund is not to be formed, the Government should establish a fund for the protection of policyholders in consultation with the industry, and membership in such a fund should be mandatory for Ontario-licensed property and casualty insurers.

D.19 Any fund established should be funded by both regular assessments to allow accumulation of funds and special assessments based on experience.

How are the insurers accountable for their financial activities?

D.20 The appropriate federal and Ontario legislation should be amended to authorize the respective Superintendents of Insurance to require the filing of interim financial statements from such companies, in such form and with such frequency as required by the Superintendent.

D.21 The federal and provincial regulatory authorities should expedite completion and implementation of the new uniform annual statement, and all parts of such annual statement should be made available to the public in a cost-efficient form.

D.22 A permanent federal-provincial consultative mechanism consisting of a council of ministers responsible for financial institutions should be established and early priority should be given to establishing new industry-wide reporting and disclosure requirements with respect to critical aspects of the industry's operation, in particular:

- overall profitability;
- profitability by lines of insurance and by various geographic regions;
- elements of operating costs, including selling, claims adjusting, legal and various administrative and transactions costs; and
- differences in operating costs among various lines of insurance.

MARKET REGULATION

The Insurance Contract

D.23 The right of insurers to design insuring contracts to meet consumer needs without prior approval should be continued, and the right of the Superintendent of Insurance and Minister to disallow contracts that are unfair, fraudulent or not in the public interest should be maintained.

Brokers and Agents

D.24 All primary insurers should establish committees with their brokers that will develop mechanisms responsive to consumers and strengthen communication.

D.25 The Insurance Bureau of Canada and The Insurers' Advisory Organization, together with the Insurance Brokers Association of Ontario, should accept and adopt as their mandate the promotion of risk management services through appropriate arms of the insurance industry, in order that public education of risk management services and loss prevention control can be co-ordinated, promoted, and the public assisted, particularly those insureds facing difficulties with respect to liability insurance coverage.

D.26 The Government of Ontario, through the Interministerial Committee established to deal with property and casualty insurance problems, should take the lead in encouraging a debate over the appropriate balance of responsibility for such loss prevention measures among individuals or businesses, insurance companies and public bodies.

D.27 The Government of Ontario should promote more research and development into product and safety standards, more training of personnel in loss prevention and control (see, for example, the IAO's School of Loss Control Technology), and more public education. Finally, the Government should require more data collection on the causes and extent of losses of all types.

Superintendent's Role

D.28 The Superintendent of Insurance should include in his annual report to the Minister a special report with respect to the progress of industry associations towards achieving the necessary structural changes to the system encompassed in the foregoing recommendations.

Advance Notice of Changes

D.29 The insurance brokers (through their association, the Insurance Brokers Association of Ontario) and the insurers (through the Insurance Bureau of Canada), under the aegis of the Superintendent of Insurance, should develop guidelines which will ensure timely notification to insureds of changes in price, coverage, exclusions and non-renewal. This recommendation is made on the basis that marketplace guidelines would be the best solution but on the express understanding that failure to arrive at a solution would result in a mandated standard, in each instance, by government regulation.

Rate Regulation

D.30 The Government of Ontario should seriously consider the implementation of a systematic framework for the monitoring, surveillance and evaluation of rates with a view to ensuring greater rate stability and public understanding of the determinants of rates and the basis for the rate changes.

D.31 The Superintendent of Insurance should be required to file an annual report to the Legislature forthwith after the end of a calendar year but not later than April 30, providing disclosure of the loss and expense data and a review of the competitive indicators monitored by his office.

SUPERVISION OF INSURERS

Cease and Desist Orders

D.32 The insurance legislation of Canada and Ontario should be amended to authorize the respective Superintendents of Insurance to issue orders requiring a registered or licensed insurance company to

a) cease doing any act or pursuing any course of conduct that might reasonably be expected to prejudice or adversely affect the interests of policyholders of the company or to result in the company being in violation of its governing legislation; and

b) take specific courses of action that appear necessary to protect the assets of the company or their value, to ensure that the company carries on its business in a sound, businesslike manner and generally to safeguard the interests of policyholders,

and that, in particular, the Superintendent be authorized to proceed without prior notice to the company in circumstances where the vital interests of policyholders or the public may be prejudiced by delay.

Corporate Governance

D.33 Federal and provincial authorities should accord immediate priority to revision of insurance legislation to bring it into line with modern approaches to corporate law generally and sound business practices for insurance companies in particular, and resulting legislative amendments should include a provision requiring regular review of the legislation governing insurance companies.

Supervisory System

D.34 The federal, provincial and territorial governments should immediately establish a Council of Ministers Responsible for Financial Institutions to consider in advance all matters pertaining to the policies and regulatory practices governing financial institutions, including property and casualty insurance companies.

TAXATION

Compensation for Future Care Costs

D.35 The taxation of revenue from lump sum settlements which arise as compensation for the economic losses of injured persons under the heading of costs of future care should be abolished. This would eliminate gross-up with respect to the costs of future care.

D.36 The practice of exempting structured settlements for compensation for the economic losses of injured persons under the heading of costs of future care should be continued and codified.

Self-Funded Reserves

D.37 The tax laws should be changed to allow corporations to take deductions on self-funded reserves in the same way that an insurance company can on its claims reserves, subject to appropriate controls to avoid abuse.

Captive Insurers

D.38 The tax treatment of captive insurance companies should be examined, alongside the regulatory aspects of such captives, with a view to promoting the domestic domicile of such captive property and casualty insurance companies as are considered to be an appropriate part of the Canadian property and casualty insurance markets.

Reserves (Stabilization and Major Shock Losses)

D.39 Property and casualty insurers should develop, with the tax authorities, a set of rules for the deduction of premium deficiency reserves where an insurer has a premium deficiency reserve program and includes such reserves on its balance sheet, and provision should be made for rules regarding additions to such reserves as an expense item for the measurement of the taxable income of the insurers.

D.40 The industry, the regulatory authorities and the tax authorities should explore means of improving the provision and use of reserves against major shock losses, related particularly to disasters due to natural causes, including the taxation treatment of such reserves.

A MORE ACTIVIST ROLE FOR GOVERNMENTS IN PROPERTY AND CASUALTY INSURANCE

Government Insurance Corporation

D.41 **The Government of Ontario should NOT establish at this time a government insurance corporation to deliver auto insurance services.**

D.42 **The Government of Ontario should concentrate its efforts regarding auto insurance on improvements in the design of the system set out in Part C, which it is contemplated will be delivered by an evolving private insurance market system.**

D.43 **If the Government of Ontario does choose, for a balance of political and social reasons, to establish a government insurance corporation to deliver auto insurance services, it should take steps as indicated in the Chairman's memorandum to try to ensure a "good performing" rather than a "poor performing" government corporation. This is not a simple or easy task.**

Governments as Animators in the Property and Casualty Insurance Market

D.44 **The Government of Ontario should consider a more activist role in insurance and reinsurance, in association with the industry, to meet the difficult structural problems of uninsurable risks and uncertainty, particularly as regards product liability (especially in relation to exports to the United States), pollution and environmental risks, the services of the province and of its creatures, professional services and voluntary activities. Some of these problems appear to be enduring rather than transitory, and a government insurance corporation may well be an appropriate vehicle for helping to deal with these problems.**

CONCLUSIONS

CONCLUSIONS

Summary of Conclusions

The Task Force has concluded that:

- Risk and property and casualty insurance in Canada are undergoing fundamental structural changes.
- These changes are rooted in technological, social and judicial changes that have altered and destabilized the risk environment.
- These changes have not only increased the risks for which insurance is sought, but have introduced massive increases in uncertainty.
- The property and casualty insurance industries have been attempting to adapt to these changes, while at the same time carrying an enormous baggage of insurance problems over from past contracts, many of them going back decades.
- The problems generated by the changes to the risk environment have been exacerbated by the effects of the insurance "cycle" as the industry shifts from a "soft" to a "hard" market.
- The concentration of both structural and cyclical difficulties has been greatest in general liability insurance. The ultimate impact of the insurance cycle is also disproportionate because of severe perception and response lags within the industry; these lags are due to the poor level of information and analysis generated by, for and about the industry; improvements in this area would significantly improve industry efficiency and economic responsiveness.
- The "hard" market phase of the current insurance industry cycle was delayed and muffled, particularly in Canada, by unusual reinsurance and investment income factors; eventually, however, a wrenching and disproportionate market adjustment took place.
- Because of the current fragmented structure of the industry, when cyclical adjustments in price and retrenchment of markets do take place, the re-establishment of a satisfactory price-cost relationship is generally slow; indeed, the current crisis indicates that cyclical over-adjustment in price and availability of insurance continues to be the norm.
- A hangover in underwriting losses in other lines of insurance, particularly for bodily injury, also exists.
- The increasing size and unpredictability of judicial awards and extra-judicial settlements for bodily injuries arising from accidents of all kinds are of great concern in the United States; this concern has prompted hundreds of proposals in the United States for tort reform, mainly by the legislative branch of governments, desirous of asserting more control over the compensation process by imposing limits on tort awards.
- Regarding risks, awards and insurance, Canada is far from becoming a "California of the North" — however, the developments in the risk environment, in the expanded interpretation of liability, and in the dramatic increase in the value of awards and settlements in Canada are similar to the American developments, and have the same fundamental causes.
- The lack of systematic data on awards and settlements in Canada has caused great difficulties both in understanding the real situation in Canada and in explaining the differences from the American situation.

- Although many participants are rightfully proud of what has been accomplished within the tort/litigation system in Canada during the last few decades, virtually no one is satisfied with the status quo.
- Many thoughtful and constructive suggestions have arisen for tort reform in Canada; most contemplate modest steps designed to improve the fairness and efficiency of the tort/litigation system in Canada, and to thereby enhance the predictability of risk and the ability of the insurance industry to serve the public.
- A number of these proposals have immediate merit, but others require more careful study.
- An impressive case, however, has been made for more fundamental structural changes to the current Canadian accident compensation and system.
- Therefore serious research and planning work should be undertaken in Canada, and in particular in Ontario, anticipating fundamental reforms to the current accident compensation and deterrence systems.
- The case for significantly improving Ontario's current automobile accident benefit system is even stronger; the Task Force recommends immediate discussions between the industry and the Government of Ontario to design and implement a comprehensive no-fault automobile accident benefit system.
- The Task Force has recommended against the immediate establishment of a government insurance corporation for the provision of the compulsory elements of automobile insurance. The Task Force suggests that there are other more important insurance matters in Ontario that are deserving of the government's political capital and energy. The Task Force also believes that these requirements can be adequately supplied by private industry.
- Another matter that requires urgent attention is the introduction of claims-made policies in the field of general liability insurance.
- It appears unlikely that completely autonomous private market actors will be able to provide satisfactory property and casualty insurance services in the near future for some problem areas. More specifically, government assistance may be required in the following areas: product liability insurance for exports to the United States, some areas of professional liability, municipal insurance, voluntary sector insurance and insurance for environmental damage and pollution liability.
- The regulatory framework for the property and casualty insurance industries requires improvement in the following areas: solvency requirements; financial management standards; disclosure requirements; incentives to generate information; and market service performance standards. The Task Force has reviewed all the proposals extant and has suggested its own regulatory package.
- Risk limitation and control has been relatively neglected in a number of activities in Ontario. A more systematic, integrated risk management and insurance approach should be encouraged.
- Finally, a Legislative committee should be established to review, at least annually, the performance of the property and casualty insurance industries in Ontario; in addition, this committee's mandate should include a consideration of judicial awards, extra-judicial settlements and the transactions costs for each compensation mechanism.

The Urgent Need for More Statistical Analysis and Information

The gaps in statistics and analysis have been touched upon many times in the Report. But the Report would not be complete without one more *cri-de-coeur* for a major effort at improvement.

Over and over again, the Task Force has had to argue that in matters of property and casualty insurance Ontario is *not* a "California of the North". Skeptics keep demanding hard evidence, not lessons in comparative civics. But for far too many critical matters the evidence is non-existent or inadequate.

Over and over again, the Task Force was told that the cost of insurance had increased because of social inflation in awards and settlements, in and out of courts. Almost as frequently, the Task Force was told that there had been no increases in real terms in awards and settlements. In response to this debate the Task Force is confident that there has been a significantly higher rate of increase in awards and settlements than the average increase of inflation rates. However, the Task Force's conclusion is basically qualitative. Without additional data and analysis nothing more was possible. Indeed, without more information, hypotheses of all sorts remain unchecked and unverifiable. More importantly, the defenders of the status quo will be able to continue to assert that there is no evidence to support any criticism or proposals for change.

The information gaps are not quite so serious for the evaluation of the solvency, reserve and profitability of insurers. Much of the relevant material is published by, or under the authority of, the Superintendent of Insurance from the Annual Statements that insurers must file. However, there remain important gaps even on these matters. The schedule for the new reporting forms that are proposed for general usage in 1986 will improve the situation. Actuarial certification of reserves would also assist, if and when that practice comes into general use.

One of the main gaps in statistics and analysis concerns legal costs broken out from claims paid by the insurance companies. At present, it is all too easy for accusations to be made that legal costs are the dominant part of the whole set of transactions costs, and that they eat up an inordinately high proportion of both the premium and the revenue dollar. In the United States, it is common to encounter assertions that legal costs eat up 75% of the premium dollar in liability insurance. Until reliable statistics are available and careful analysis is made of the role of legal costs in the Canadian property and casualty insurance chain, it will not be possible to answer such accusations. More importantly, without such information it will be impossible to compare the costs of alternative adjudication and dispute resolution processes.

Another gap in statistics and analysis is presented by the inadequacy of information on which to evaluate the cost-benefit experiences of risk management and control efforts such as safety programs, improved safety of products, etc. There are some examples in Canada where such data are available and where careful analysis has been possible. These examples demonstrate the remarkably high payoff that can be attained from some safety programs.

A number of other deficiencies in statistics and analysis have turned up in the work of the Task Force: specifically, data on accidents other than automobile or industrial; integrated data bases needed to run an efficient and fair bonus-malus system; and even data on the price and availability of some insurance services.

For an industry that depends on numbers, and that does such an impressive job in assembling and analyzing data for many rate-making purposes, the gaps in statistics and analysis sketched above are puzzling. For reasons which the Task Force was not able to fathom, statistical and analytical exercises, which are both possible and could be done economically with modern information technology, are either not done, or are done incompletely and ineffectively.

The Task Force suggests that the industry associations and the government authorities make a special effort to develop statistical and analytical programs to fill most of the gaps noted above. Much the same plea was made about a decade ago in the excellent reports of the Select Committee on Company Law. Not much has happened in the intervening decade. In this crisis, the public and the industry have suffered more than they needed to, in part because of the confusions resulting from the gaps in statistics and analysis. It would be unfortunate if a Task Force or a Legislative Committee a decade from now had to repeat this plea.

APPENDICES

APPENDIX 1

LIST OF BRIEFS AND SUBMISSIONS

Briefs

Advocacy Resource Centre for the Handicapped
The Advocates' Society
Allstate Insurance Company of Canada
The Association of Canadian Insurers
The Association of Ontario Motels & Motor Inns
Association of Professional Engineers of Ontario
Automobile Protection Association
Behavioural Health Inc.
The Board of Trade of Metropolitan Toronto
Brown, Craig and Elizabeth Cummins Seto (University of Western Ontario)
Brown, Robert L.
Building Industry Development Board
Buset & Eyrou (Barristers & Solicitors)
Canadian Automotive Leasing Association
Canadian Bar Association (Ontario)
Canadian Chemical Producers' Association
Canadian Export Association
Canadian Independent Adjusters' Association
Canadian Institute of Actuaries
Canadian Institute of Public Real Estate Companies
The Canadian Life and Health Insurance Association
Canadian Manufacturers' Association
Canadian Medical Protective Association
Canadian Organization of Small Business
Canadian Paraplegic Association
Canadian Reinsurance Company
Consulting Engineers of Ontario
Consumers' Association of Canada (Ontario)
The Co-operators General Insurance Company
The Corporation of the City of North Bay
The Corporation of the City of Brantford
F & W Property Management Ltd.
Facility Association
Friedland, Seymour
Futerman, Jack
Hogan, Michael A.
Municipal Electric Association
The Municipality of Metropolitan Toronto
McKellar Structured Settlements Inc.
McMaster University Faculty of Health Sciences
McTavish, Wilson A.
National Insurance Managers Inc.
New Democratic Party
Niagara Falls Taxi Ltd.
Northern Frontier General Insurance Company
Northern Ontario Tourist Outfitters Association
The Ontario Association for the Mentally Retarded
Ontario Association of Architects
Ontario Automobile Dealer Association
Ontario Camping Association
Ontario Chamber of Commerce
Ontario Federation of Agriculture
Ontario Fruit and Vegetable Growers' Association
Ontario Good Roads Association
Ontario Greenhouse Vegetable Producers Marketing Board
Ontario Hospital Association
Ontario March of Dimes
Ontario Motor Coach Association
The Ontario Mutual Insurance Association
Ontario Natural Gas Association
Ontario Petroleum Association
Ontario Petroleum Institute Inc.
Ontario Risk and Insurance Management Society
Ontario Sailing Association
Ontario Sports Medicine and Safety Advisory Board
Ontario Trucking Association
Ontario Water Ski Association
Patients' Rights Association
Pensa, Claude
Philpott, Lorne (H.L. Staebler Company)
Pool Insurance Managers Ltd.
The Professional Liability Insurance Program — A Plan for Ontario Dentists
Reed Stenhouse

Income Maintenance for the Handicapped
Insurance Brokers' Association of Ontario, Toronto Insurance Conference
The Insurance Bureau of Canada
Insurers' Advisory Organization of Canada
Kenora District Municipal Association
Marsh & McLennan Limited
The Mercantile & General Reinsurance Company of Canada
Ministry of the Attorney-General
Ministry of Industry, Trade and Technology
Ministry of Transportation and Communications
Municipal Affairs Insurance Advisory Committee
Regional, District and Metropolitan Solicitors' Group
Regional Municipality of Niagara
Registered Nurses' Association of Ontario
Reinsurance Research Council
Ross, Angus H.
St. John Ambulance
Siskind, Cromarty (Barristers & Solicitors)
Society of Fellows, Insurance Institute of Canada
State Farm Insurance Companies
Tourism Ontario Inc.
Trial Lawyers Association of British Columbia
Urban Finance Officers Association of Ontario
Wellington Insurance Company
Western General Mutual Insurance Company

Submissions — Associations

Academy of Defensive Driving
Air Products Division Stearns Catalytic Ltd.
Algoma Farmers Market
Association of Municipalities of Ontario
Canadian Association of Exhibitions
Canadian Association of Movers
Canadian Association of Municipalities
Canadian Federation of Independent Business
Canadian Towing Society
CAPS Nursing Service
Catholic Youth Organization
City of Port Colborne
Consumer Chemical Limited
The Corporation of the Town of Campbellford
County of Lambton
Del Equipment Limited
Denny Bus Lines
Duncan Insurance Services Limited
Electrical and Electronic Manufacturers Association of Canada
Equicon Engineering Limited
Federation of Northern Ontario Municipalities
Halton Taxi Services
Hunter, Winn Underwriting Management Limited
Ontario Hotel & Motel Association
Ontario Law Reform Commission
Ontario Motorcycle Dealers' Association
Ontario Ski Resorts Association
Port Colborne General Hospital
Public Utilities Commission of the City of Kingston
Quinte Insulators Ltd.
Registered Insurance Brokers of Ontario
Reliable Taxi Newmarket (1978) Ltd.
Royal Insurance Canada
School Bus Operators' Association of Ontario
Simcoe & Erie Group
Sorge Insurance Brokers Ltd.
Toronto Insurance Conference
Township of Hope
Township of Ignace
The United Senior Citizens of Ontario
Vanderhout Insurance Limited
Whisper Trading Ltd.
Willowgrove
Zehr Insurance Brokers Ltd.

Imtrex Commodities Inc.
J.B.M. Murray Ltd.
The Law Society of Upper Canada
Lincoln County Roman Catholic Separate School Board
L-Tec Welding & Cutting Systems
Mechanical Contractors Association (Ontario)
Minden, Gross, Graftstein & Greenstein (Barristers and Solicitors)
Motorcycle & Moped Industry Council
Northwestern Ontario Municipal Association
Northern Ontario Tourist Outfitters Association
Ontario Advisory Council on the Physically Handicapped
Ontario Equestrian Federation Inc.
Ontario Horse Trials Association

Submissions — Individual

Allen, Barry
Anderson, Hugh
Anzivino, Roberto
Armstrong, Doug
Bailey, Shirley
Berlovitch, Harold
Birch, G.W.
Birrell, Terry
Bond, Penny
Bray, Charles
Bresler, Sam
Burrow, Ken
Cameron, J.R.E.
Caplan, The Honourable Elinor
Cerisano, Stanley
Cheslock, Donnie
Chester, Jean
Clancy, H.A.
Creek, G.E.
Currelly, Madelaine
Dawson, Dave
Dean, Dora
Diehl, Susan
Ducharme, Clifford
Eakins, The Honourable John
Gaviller, David
Ghent, Harold
Gordanier, E.J.
Greaves, G.
Harrison, Harry Jr.
Hitchlock, Ronald
Johnston, Carman R.
Lasani, A.
Mang, Ian
Matchett, R.P.
Mirander, Kenrick
McBride, Ron
Munro, The Honourable Lily
Noel, Rodney
Phillips, Sanford
Piekutowski, R.
Polley, Ken
Prager, Lothar M.
Reeve, Peter E.
Riddell, The Honourable Jack
Riddle, Gerry
Ringer, Howard
Sanderson, John A.
Sands, W. George
Scuro, Carol
Searle, James D.
Tatomir, John
Tawse, W.J.
Wilson, Dave
Yan, Andrew

APPENDIX 2

RESEARCH STUDIES AND SURVEY PAPERS

Clendenning, E. Wayne, "A Discussion of the Implications for General Insurance Activities Arising from Recent Financial Sector Reports and Legislation".

Coopers & Lybrand, "The Financial Performance of the Property and Casualty Insurers"; "Review of Trends and Cycles in Availability and Price of General Insurance Services"; and "Summary Paper: Causes of and Prospects for the Current Cycles in Availability and Price, Financial Performance and Reserve Experience in the General Insurance Industry".

Krossel, Martin, "The General Insurance Industry and Financial Conglomorates".

Mathewson, Frank and Winter, Ralph, "The Market for Property and Casualty Insurance in Ontario".

Osborne, Philip, "A Critical Evaluation of Liability Insurance, Litigation and Personal Injury Compensation: The Lessons and Choices for Ontario".

Rea, Sam, "Economic Analysis of Fault and No-Fault Systems".

Trebilcock, Michael J., "The Insurance-Deterrence Dilemma of Modern Tort Law: Trends in North American Tort Law and Their Implications for the Current Liability Crisis".

Tuohy, Carolyn and Chandler, Marsha, "The Role of Government in the Insurance Arena In Ontario: A Political Analysis".

Woods Gordon Management Consultants: "Research Paper — Automobile Rating Classifications"; "Research Paper — The Distribution System"; "Research Paper — Government Presence in Ratemaking"; "Research Paper — Liability Insurance"; and "Research Paper — "The Claims-Made Liability Policy Form".

APPENDIX 3

GLOSSARY OF INSURANCE TERMS

Abandonment

To give up rights and duties in the item insured. All insurance policies, except Marine, forbid abandonment by the insured of the article insured without the consent of the insurance company.

Act of God

A direct, sudden and irresistible act of nature, such as could not have been foreseen or, if foreseen, its effect could not have been prevented — an inevitable accident, e.g., flood, earthquake, etc.

Actual Cash Value

The current value of an insured article at the time of a loss. This may be the cost of replacing the article with a similar model in similar condition. It may, however, involve the price of the article plus any appreciation or less depreciation since its purchase.

Actuary

A person trained in the "principle of large numbers" and the "theory of probability", who calculates the proper premium rates based on experience and often considers the accuracy of the assesment of reserves.

Adjuster

The person who investigates insured losses and negotiates the settlement of claims on behalf of the insurer. Public adjuster is one who, for a fee, represents policyholders in the adjustment of their losses with insurance companies.

Adjustment

The process of arriving at the settlement of a claim. It may consist of a series of computations in an uncomplicated fire loss or it may involve discussions of the degree of liability, quantum of damages and other matters in problem liability claims.

Agent

The **independent agent** is an independent businessperson who represents two or more insurance companies under contract in a sales and service capacity and who is paid on a commission basis. The **exclusive agent** represents only one company usually on a commission basis. The **direct writer** is the salaried or commissioned emloyee of a single company. Agents are licensed in the province(s) in which they operate.

Aggregate

The dollar amount of insurance coverage during one specified period, usually 12 months, for all insurance losses sustained under a policy during such period.

Appraiser

The person called upon to establish quantum or the extent of material loss resulting from a claim, or to assist in the underwriting of a risk, usually recognized as an expert in his field of endeavour, i.e., real estate, gemology, automotive or industrial equipment. The **independent appraiser** is an independent businessperson who represents many insurance companies, reporting to the adjuster or company. The **staff appraiser** represents one company exclusively and reports directly to that company. The **adjuster's appraiser** usually represents one independent adjuster and reports directly to that adjuster.

Arbitration Clause

Language providing a means of resolving differences between the company and the policyholder without litigation. Usually, each party appoints an arbiter. The two thus appointed select a third arbiter, or umpire, and a majority decision of the three becomes binding on the parties to the arbitration proceedings.

Assignment

The transfer of an interest from one party to another. Insurance policies are personal contracts and are not transferable except by consent of the insurance company.

Binder

An agreement to cover a risk pending the issuance of a policy. It is also known as a "cover note".

Blanket Rate

Uniform premium rate for everthing insured under one policy. It may involve several properties.

Boiler and Machinery Insurance

Coverage for loss arising out of the operation of pressure, mechanical and electrical equipment. It may cover loss suffered by the boiler and machinery itself and may include damage done to other property, as well as business interruption losses.

Bond

A bond issued by an insurance company generally protects an individual or corporation, known as an obligee, from loss arising out of the acts or failure of another, known as the principal. Basically there are two types of bonds — surety bonds and fidelity bonds.

Broker

A marketing specialist who represents buyers of property and liability insurance and who deals with either agents or companies in arranging for the coverage required by the customer. Like the agent, the broker is licensed in the province or provinces in which he conducts his business.

Building Rate

The fire insurance rate on a building (real property), as distinct from the rate on the stock or contents, etc.

Cancellation

The termination of the policy before the end of a policy period. Usually if the company cancels the policy, the insured is entitled to a pro rata return of premium for the unused portion of the policy. If the insured cancels, he is entitled to a reduced refund of premium.

Casualty Insurance

The group of coverages which includes insurance against liability claims and almost all other types except fire, marine and life.

Claim

The demand for payment under a policy as a result of loss or damage sustained by the insured or a third party.

Claim Reserve

The amount of money set aside by an insurance company for a reported claim that has not been settled.

Co-Insurance

A clause in an insurance policy providing for the sharing of the loss unless the policyholder maintains insurance on his property or contents up to a stipulated percentage of its value.

Comprehensive Automobile Insurance

This type of automobile insurance provides coverage to repair your car when it is damaged in circumstances other than by a collision, e.g., fire, theft, vandalism, glass breakage, etc.

Compulsory Automobile Insurance

Many jurisdictions in Canada and the U.S.A. require evidence of the existence of valid third-party liability automobile insurance before a motor vehicle permit will be issued or renewed. In some jurisdictions, accident benefits and collision coverages may also be compulsory.

Concurrent Insurance

Where two or more insurance policies are alike in all material aspects, both insurance policies apply concurrently to the loss and are known as concurrent insurance.

Contents Rate

The rate set for insurance on the contents of a property rather than the building itself.

Cover Note

An agreement to cover a risk pending the issuance of a policy. It is also known as a "binder".

Daily Report

The insurance company's (or agent's) record of the policy. It usually includes the application, the carbon copy of the typewritten parts of the policy and the endorsements. It omits the cover form and lengthy portions of the policy which are standard to the particular company's policy of that type.

Damages

A sum of money claimed or awarded as compensation for loss or injury.

Deductible Clause

Some policies are written to pay only after the policyholder has himself suffered an agreed amount of loss. The amount which he must lose first is "deducted" from the total of the damage to determine the amount the company must pay and thus becomes the "deductible".

Effective Date

The date at which the protection becomes effective.

Endorsement

An endorsement is a modification which is added or attached to an existing policy.

Estoppel

The legal bar raised by one's own actions against asserting a right which once existed. See also "Waiver".

Excess Insurance

Excess insurance means insurance which becomes effective only when the loss is in excess of a certain amount or where it is in excess of the basic policy.

Ex Gratia Payment

A payment made for which the company is not liable under the terms of its policy.

Expense Ratio

The percentage of premium used to pay all the costs of acquiring, writing and servicing insurance.

Expiration

The date set in the policy when it is to expire.

Exposure

The hazard threatening a risk because of external or internal physical conditions.

Extended Coverage

An endorsement that enlarges the coverage afforded by the policy. In fire policies, the "Extended Coverage" adds still more perils such as accidental leakage of plumbing and heating systems, vandalism, etc.

Financial Responsibility Law

A statute which requires motorists to be able to establish their financial ability to pay losses up to a certain minimum dollar limit. The most usual form of proof is an insurance policy. This law assures availability of money to pay damages arising from an automobile accident for which the policyholder is legally liable.

Floater Policy

A policy covering the same risk at a number of unspecified locations, and usually including suggestions of goods being frequently moved from one location to another, e.g., Fur Floater, Jewellery Floater.

Form

Generally the printed part of a policy is referred to as the "form". There are printed parts for most policies and these are frequently identified as the "fire form", "liability form", etc.

Franchise

A provision in an insurance policy whereby the insured pays claims up to a predetermined amount. If, however, any loss exceeds that amount, then the insurance company assumes responsibility for the full amount of the loss including the franchise amount. (See "Deductible".)

Green Book

An annual automobile experience exhibit produced for government by the statistical arm of Insurance Bureau of Canada.

Guaranteed Cost

Premium charged on a prospective basis which may be fixed or adjustable on a specified rating basis but never on the basis of loss experience.

Homeowner's Policy

A package policy designed to cover the various risks of a homeowner. Coverages for the building, personal property and legal liability are incorporated into one contract.

Insurable Interest

To make insurance policies legal and valid, the insured must possess such an interest in the subject of insurance as may be sufficient to involve him in a monetary loss, should the subject be damaged or destroyed. In other words, if he has a direct monetary interest in the property to be insured, or the risk to which he is exposed, he has insurable interest. This interest may be of various characters — it may be that of an owner, a lessee, a guardian, a bailee, an executor, an administrator, a bailiff, a sheriff or a creditor. As long as there is a real monetary interest, there is an insurable interest.

Insurance

The undertaking to indemnify another person against loss or liability for loss in respect of specified perils or upon the happening of a specified event.

Insured

One who transfers a risk to another. The person named in the agreement of indemnity from an insurance company (or person) affording them indemnity from perils as set out therein. Interchangeable with "assured".

Insurer

The insurance company which has agreed to accept the risk and to supply the indemnity to an insured in the event of loss.

Insuring Clause

The part of the insurance policy which sets out the specific agreement to protect against the particular peril for which the insurance is purchased. It is an essential part of all insurance contracts.

Legal Liability

The responsibility imposed under law upon one person to another whether by common law, statute or contract.

Liability Insurance

Provides protection for the insured against loss arising out of his legal liability resulting from injuries to other persons or damage to their property.

Lloyd's

A broad term used to designate a group or groups of individuals, known as syndicates, not insurance corporations or companies, assuming liability through an underwriter. Each individual independently assumes a proportionate part of the insurance accepted by the underwriter.

Loss or Damage

Loss is technically distinguished from damage in fire insurance when all or any portion of the property insured is consumed. "Loss" designates that portion which is entirely consumed, while "damage" designates that part of the property which is not consumed, but remains after a fire in a damaged condition.

Loss Ratio

Proportionate relationship of incurred losses to earned premiums expressed as a percentage.

Malpractice Insurance

Coverage afforded to a professional practitioner, such as a doctor or lawyer, against liability claims for damages resulting from alleged negligence in the performance of the insured's services.

Merit Rating

A system of rating whereby the insured with a good experience obtains benefits at a lower rate. Commonly used in automobile insurance where a driver who is accident-free for a certain period of time is given a discount from a listed rate he would otherwise pay.

Mortgage Clause

A policy provision containing an agreement to notify the mortgage holder of changes in the policy, to have his rights unaffected by acts or omissions of the insured, and to have every loss payable to him as his interest may appear.

No Fault (Automobile)

A common description of insurance which will pay the insured person and others involved in accidents without determining his degree of fault. Examples are collision insurance and the limited accident benefits.

Open Cover

An agreement under which risks of a specified category may be declared and insured. Most frequently used in marine insurance.

Package Policy

A combination of the coverages of two or more separate policies in one contract with one premium.

Peril

This term refers to the causes of possible loss in the property field, for instance, fire, windstorm, collision and hail. In the casualty field, the term "hazard" is more frequently used.

Policy

The actual contract of insurance with all its details.

Pool

An organization of insurers or reinsurers through which particular types of risks are underwritten with premiums, losses and expenses shared in agreed ratios.

Premium

The sum of money paid by an insured in consideration of the acceptance of a risk by an insurer. **Earned premium** is the proportion of the total premium which would pay for insurance from the inception date of the policy until the particular date at which it is desired to calculate the earned premium. **Direct premium** is the total premium received from all sources including reinsurance assumed from other companies. **Written premium** is the total amount of premium collected on that class of business or on all classes of business.

Premium Deposit

When the terms of a policy provide that the final earned premium be determined at some time after the policy itself has been written, companies may require tentative or deposit premiums at the beginning which are re-adjusted when the actual earned charge has been later determined.

Proof of Loss

The written document signed by the insured, formally making a claim against the insurer.

Property Insurance

Provides financial protection against loss or damage to the insured's property caused by such perils as fire, windstorm, hail, explosion, aircraft, motor vehicles, vandalism, malicious mischief, riot and civil commotion, and smoke.

Rating Bureau

A non-profit organization of insurance companies formed to promulgate rates for its members and subscribers.

Recovery

The amount of loss which an insurance company gets back from reinsurance, salvage or by subrogation against the person responsible for the loss.

Reinsurance

The process whereby a company may share its risk with another, paying to such sharing company a portion of the premium it receives. Loss payments are made by the company accepting the reinsurance directly to the producing company, not to the policyholder.

Renewal Certificates

The form used to change the expiry date of the contract.

Replacement Cost Insurance

Insurance which pays the full value of damaged or destroyed property without taking depreciation into consideration.

Reserve

See "Claim Reserve" and "Unearned Premium Reserve".

Retrospective Rating

A plan or method which permits adjustment of the final premium on the basis of the actual loss experience under the subject policy, subject to minimum and maximum limits.

Self-Insurer

An individual, partnership or corporation who retains all or part of the risk for its own account and purchases an excess of loss cover to protect itself in the event of a catastrophe.

Subrogation

When a company pays a loss for which some person other than the policyholder is responsible, the company's right to recover its loss from the guilty party is the right of subrogation.

Suretyship

(1) The function of being a surety; (2) Stated in its simplest terms, suretyship embraces all forms of obligations to pay the debt or to answer for the default of another.

Syndicate

In insurance, usually a group of companies or other underwriters who join together to insure certain property which may be of such value, or of such high hazard, or so expensive to underwrite that it can be done on a co-operative basis more efficiently. (See "Lloyd's".)

Term

The period of time from the inception to the termination of an insurance contract.

Third Party

The claimant under a liability policy. So called because he is not one of the two parties — insured and insurer — who enter into the insurance contract which pays his claim.

Tort

An act or omission that may give rise to an action in damages.

Umbrella Policy

A form of excess liability insurance available to corporations and individuals protecting them against claims in excess of the limits of their basic policies, or for claims not covered by their insurance program.

Underwriter

The insurance company or group that underwrites or insures a particular risk. It is also used to identify the individual in the company who accepts or rejects business in the particular line he specializes in, and in this way, chooses risks his principals are prepared to consider.

Unearned Premium Reserve

Insurance premiums are paid in advance. A company, however, "earns" the premium only as fast as time elapses. Yesterday's premium is earned. Tomorrow's premium is unearned. The unearned premium reserve is the sum of all the unearned premiums of all the unexpired policies that a company has on its books.

Void or Voidable

A contract is void when it is destitute of all legal effect. A voidable contract is one which can be made void at the option of one of the parties.

Waiver

An intentional relinquishing of a known right. A waiver under a policy is required to be clearly expressed and in writing. See also "Estoppel".

NOTE: **The Glossary of Insurance Terms** published by the Insurance Institute of Canada has been reprinted with permission.

APPENDIX 4

BASIC TYPES OF PROPERTY AND CASUALTY INSURANCE*

I PERSONAL PROPERTY INSURANCE

II COMMERCIAL PROPERTY INSURANCE

1. Fire and allied lines
2. Business interruption
3. Crime insurance
4. Cargo insurance
5. Miscellaneous property coverages:
   — crop insurance, livestock and bloodstock insurance, floater policies, weather insurance, glass insurance, builders' risk policies, specialized property insurances

III LIABILITY INSURANCE

1. Comprehensive general liability (for all basic liability hazards of a business except for contractual liability)
   a) Bodily injury and property damage liability
   b) Products liability
      — to third parties for losses involving injury or damage by products that either a manufacturer, wholesaler or retailer deals in. Legal liability is based on negligence or breach of warranty.
   c) Employer's liability and voluntary compensation (for injury to employees not covered by workers' compensation)
2. Professional liability
   a) Errors and omissions insurance
   b) Malpractice insurance
3. Other business liability coverages
   a) Contractual liability
   b) Directors' and officers' liability
   c) Owners', landlords' and tenants' liability
4. Excess or umbrella liability (to provide catastrophe liability protection)
5. Surety Bonds
6. Fidelity bonds

IV "OTHER LINES" INSURANCE

1. Marine insurance
2. Aircraft insurance
3. Boiler and machine insurance
4. Mortgage insurance
5. Credit insurance
6. Title insurance

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*These are described in much greater but very useful detail in Appendix F to the Third Report of The Select Committee on Company Law on the General Insurance Industry, 1979.

APPENDIX 5

STRUCTURE AND OPERATION OF THE PROPERTY AND CASUALTY INSURANCE INDUSTRY IN ONTARIO

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STRUCTURE AND OPERATION OF THE PROPERTY AND CASUALTY INSURANCE INDUSTRY IN ONTARIO

Risk and Insurance

The basic concept of risk is that it reflects the likelihood of a loss to an individual, group or corporation. Risks may be evaluated by considering the probability of events or occurrences which give rise to losses, and by considering separately the size and incidences of losses attached to those events. The events or occurrences may arise from many different hazards, from which perils such as fire, theft, etc., may arise, resulting in losses. Liability claims result from the wrongdoings of individuals, firms, or corporations in either an intentional manner or by negligence. Liability claims may also arise from failure to perform or violation of contractual obligations.

The consequence of failure to provide for risks is generally demonstrated by economic loss, which can be so severe as to destroy the financial viability of an individual or corporation.

Risk Control and Reduction

Risk management has as its basic goal the reduction of the potential for loss before it occurs through a process of identification, measurement and evaluation, reduction or elimination of the risk, and financing the risk.

All individuals, groups and governments have opportunities to reduce the probability of events or occurrences which give rise to losses and to reduce the size of losses when they occur. Programs of driver training, traffic safety, and even improved maintenance of streets become programs of risk control, thereby reducing the probabilities of events or occurrences which give rise to losses.

There are organizations dedicated to these objects. These include the Ontario Risk and Insurance Management Society, which is a chapter of the Risk Insurance Management Society — a non-profit association for risk and insurance managers of commercial and industrial enterprises, public entities, non-profit organizations, and service industries. While ORIMS represents the majority of major corporations in Canada, smaller businesses and service organizations are included as well.

The Canadian Industrial Risk Insurance Association comprises some 30 insurance companies to provide a facility for wide participation of Canadian insurers in a risk-sharing mechanism, which emphasizes co-operation in loss reduction services.

There is also the Factory Mutual System, consisting of three insurance companies that provide a similar facility.

The Insurers' Advisory Organization of Canada, currently funded by some 52 groups of general insurance companies who write more than 50% of the fire and casualty insurance business in Canada, provides technical services to its members. Some of these services can be identified as: loss prevention and control — which prevent or minimize loss, including fire protection, safety, security and loss control engineering; individual risk instruction; public fire protection surveys; and the operation of a school of loss control technology. The IAO offers a risk evaluation service which develops information needed by insurers to determine premium hazards, which reflect variations in the degree of risk or hazard.

Even with these activities, there are many groups in society that are not represented or affected by these services; and it can correspondingly be seen that many opportunities exist for the development of risk reduction and control measures.

The Fundamental Basis of Insurance

Insurance in its basic form is a contractual undertaking, under which some or all of the risks of economic losses are transferred to an insurer who, for a premium, promises to compensate the insured for the losses resulting from the specified risks in the contract. The insured therefore can, by paying a premium, accept the certain cost of the premium in exchange for the transfer of a potential individual loss if the peril insured against should arise. To the person insured, though the probability of peril may be very small, the individual losses could be large or catastrophic if the peril occurred and the individual had to bear the whole loss. For an insurer to enter into such an agreement, a large number of agreements covering similar risk characteristics are required. By combining many risk exposures, it is possible to predict the collective losses and to do so, in some instances, quite accurately. The underlying principle is the law of large numbers, which, in the context of insurance, states that with an increasing number of risk exposures, the actual losses approach their expected value quite closely. The expected collective loss is then shared proportionally by all insured, in the form of premiums. The insureds also bear the cost, through their premiums, of running the system.

Presupposing that adequate capacity exists to provide insurance coverages, the availability of insurance comes into question when it is not possible to predict the collective losses for a particular group of risks with sufficient accuracy. In the case of new risks, for which there is not enough experience to develop a probability of distribution of events, there is a reluctance to insure. When offshore drilling was started in the North Sea, the probability of loss of drilling rigs in severe storms was too imprecise in calculation, with the result that insurance was only available from a relatively few insurers at very high prices.

Changes in circumstances or practice may also result in a loss distribution from various events not being calculable with sufficient precision. The current concern with respect to product liability risks in the United States is that these risks may have become so unpredictable in recent years that whatever coverage remains from a few insurers is available only at very high prices. In addition, there may be so much uncertainty surrounding a risk or the magnitude thereof that no private insurance pool, however large, can entertain the writing of such risks. An example is earthquake damage in Japan or civil war damage in Lebanon.

Transactions costs payable by the insurer may cause risks to be insurable in practice, although not in principle. Shifts in legal practice and costs, if quite uncertain in their impact, could lead to some risks being uninsurable for a time.

In a competitive, market-driven, profit-driven system, if sufficient expectations of safe and profitable insurance undertakings for various risks cannot be found, then they will be uninsurable or difficult to insure. Government regulation that might restrict expansion or control the price of insurance service may make markets unprofitable, though they would not be fundamentally so.

The Insurance Process

First-Line Insurance. First-line insurers are those who formally enter into the primary insurance contract with an insured. A large proportion of such contracts are not negotiated directly between the insured and the insurer, but are entered into and administered through a network of agents and brokers. A substantial proportion of the contracts are entered into by what are called direct writers, that is, by insureds dealing with the exclusive agents of an insurer (in Ontario, Allstate, the Co-operators and State Farm are the best known of the direct writers). The first-line insurers come in a variety of institutional forms in Ontario: joint-stock companies, mutuals, co-operatives, reciprocals and pools. Some are Canadian-chartered, some Ontario-chartered, some foreign-chartered.

The first-line insurers may pass part of the risk they enter into in the first instance to reinsurers, in return for a share of the premium income. An elaborate network of reinsurance, through various institutional forms in various parts of the world, may share risks in back of the initial reinsurance arrangement of a first-line insurer. But more of this later.

Returning to the first-line insurers, generally speaking they enter into contracts in which they receive premiums early in the life of the contract, earn them over the life of the contract, meet claims later in the life of the contract or later than the premium year, and meet expenses during and after the contract. For this reason, the insurer typically has an investment fund generated from the lags between the timing of the receipt of premiums, and the timing of the expenses and payment of claims, from which investment income can arise in the first instance in the hands of the insurer. The insurer also has some earning assets from the capital and surplus supplied by the owners of the institution, from which a second source of investment income arises. In any given year the balance between the premium income and all expenses (commissions, administration, sales costs, claims costs and claims settlement expenses) is the underwriting profit or loss. The ratio of all such outlays, including charges to reserves, is called the operating ratio. The claims costs include claims paid, additions to reserves for claims pending but not paid, and additions to reserves for claims incurred but not received. The pre-tax ultimate bottom line in any given year is the sum of the underwriting loss or profit plus investment income on the lag funds and on the investment fund arising from capital and surplus (and includes capital gains or losses realized). The typical general insurance institution is primarily a risk intermediator both across individuals and across time, and a financial intermediator between liabilities of one time and liquidity, and assets of other times and liquidities.

The profit or loss of an insurance organization in any year is an amalgam of the bits of profit or loss arising from bits of underwriting business entered into in each of many years, the current one and many previous ones. In year x, for example, there may be a bit of profit or loss arising from the income, expense and claims business in year x arising from business within year $x-y$; likewise for year $x-y+1$, $x-y+2$, and so on, up to business within year x itself (y may be many years, ten or more, in which the undertakings are referred to as having long-tails). Thus, in year x, the overall profit or loss could be the result of a complex mix of profits and losses in that year arising from the results in that year of many years of underwriting. As a result, many possibilities arise. A company could appear profitable in year x, despite its recent experience being unprofitable, the losses being offset by the completion of tail transactions from the past. Conversely, a company could show losses in year x, when in fact year x and other recent transactions are profitable, though these profits are overwhelmed by the completion of loss business emanating from the tail.

The Reinsurance Process. It is standard practice for first-line insurers to pass on or to "cede" a portion of their risks to a network of reinsurers, the reinsurers accepting a portion of the risk in return for a portion of the premium income. Many different arrangements may be made, in bulk or case by case, with various deductibles and layers, and through various channels. These need not be examined at this point. But it is worth noting that first-line insurers may engage both in ceding to and accepting contracts from reinsurance networks, depending on the mix of risks which they consider to be appropriate. When the first-line insurer has claims to settle and pay, the reinsurer will share in the funding under the terms of the reinsurance contracts. The reinsurer's share of the claim may be small or large depending on the nature of the occurrence, the size of the claim and the terms of the contract.

Brokers and Agents. The vast majority of the public in Ontario meets the insurance industry through brokers or agents. Brokers may represent any number of insurers who will accept their business. They are registered under a self-governing statute called the *Registered Insurance Brokers Act* of Ontario. Agents are exclusive to the company who appoints them and are licensed under the *Insurance Act* of Ontario.

Brokers account for about 80% of the placement of the market, compared to some 20% for direct writers such as Allstate, State Farm and The Co-operators. To a large degree, direct writers only engage in personal lines business.

Brokers are independent businessmen, who maintain their own offices throughout the province and hold themselves out to shop the market. They are paid on a percentage commission basis. Agents for direct writers work in a variety of ways and may be housed by their insurer and paid on a form of commission.

In 1984, commission and profit commission paid by insurers, for the total of personal lines, property, automobile, and other classes of insurance, amounted to 17.6% of the premiums received. For the direct writers, the commission payable constituted 5.1% of the premium received.

Main Lines of Property and Casualty Insurance

A useful summary of the main lines of property and casualty insurance is contained in the Fact Book of the Insurance Bureau of Canada. In part, it reads:

- Automobile Insurance (nearly 50% of premium income)

- Property Insurance (nearly 40% of premium income)

  Includes: fire, personal property, earthquake, explosion, forgery, inland transportation, livestock, plate glass, real property, theft, weather, windstorm.

  Although property insurance covers buildings and contents, it also includes a number of other risks that are part of package policies or purchased separately. These coverages include personal liability for homeowners and tenants, business interruption insurance for businesses, temporary accommodation costs, etc.

- Liability Insurance (about 8% of premium income)
  This coverage protects the insured for his legal liability to others for injury, death and/or damage to their property caused through or by the insured person's occupation or personal activities. It includes the increasingly important class known as Products Liability, which protects the public for injury suffered from the use of goods and services.

- Casualty Insurance (about 5% of premium income)
  - Surety and fidelity
  - Boiler and machinery insurance
  - Marine and aircraft insurance

Conventionally, insurance is also subdivided another way, into personal lines (personal automobile and property) and commercial lines (commercial automobile, commercial property, liability and casualty insurance).

General Characteristics of the Property and Casualty Insurance Industry in Ontario

The insurers operating in Canada are a mixture of Canadian and foreign-incorporated bodies which are licensed to operate in Canada. Canadian incorporation may be under federal or provincial authority. No matter what the federal government's incorporation or licensing may be for insurers, provincial licences are required for the privinces in which they operate.

Except for the insurers which are incorporated by a province (a minority of bodies both by numbers and size of operations), insurers in Canada are subject to *both* federal and provincial regulation. Though subject from time to time to jurisdictional "tugs of war" and disputes regarding the division of powers, both levels of government have by now such entrenched positions that concurrent jurisdiction is the best short description of the regulatory authority. *De facto*, the central concern of federal regulation is with the solvency of insurance companies and matters closely related thereto. The central concern of provincial regulation is with the provision of services at reasonable prices and with reasonable certainty and efficiency of delivery to customers.

As stated, in Ontario the delivery of insurance services is by a group of insurers to insureds through a decentralized market system consisting mainly of brokers and agents, and to a lesser extent through agents of direct selling insurers. Much of the cost and much of the effectiveness (for good or bad) thus depends upon the agent and broker system, and the intermediaries of adjusters.

At first impression, the industry structure among first-line insurers is predominantly atomistically competitive in most lines, but with a paradoxically concentrated structure in a few other lines. Over 150 companies compete in the automobile insurance sector; about 100 compete in the business of personal lines property insurance. These two segments make up more than 70% of the total premium writing. At the other end of the spectrum, at the time of the Task Force's work, there were two "markets" for municipal liability insurance, and two "markets" for hospital liability insurance. The large numbers in automobile and personal property lines exaggerate somewhat the atomization of the industry, because within the sectors a considerable measure of selectivity of niches within the insuring activity exists. Nevertheless, extreme measures of competition exist alongside narrow ranges of alternatives elsewhere.

Entry and exit to the industry have been very easy, both for Canadian corporations and for foreign companies.

Risk retention among first-line insurers has varied a good deal in recent years. The conventional wisdom among the old guard of the industries is that the first-line insurers should keep a large measure of risk retention, 50% more or less, depending on the line of activity and the nature of the risk. Some companies have operated in the last decade at much lower levels, some keeping such low levels at times as to be labelled "fronting companies", hardly more than brokers. Several companies which operated in this way have failed, and the conventional wisdom of the moment is to legislate higher levels of risk retention; beyond that, to attempt by suasion to have the first-line insurers operate to higher-than-legal-minimum ratios of risk retention.

It is generally agreed that, at least up to now, there have been limited economies of scale and scope in the general insurance business, especially in view of the possibilities of contracting out so many supporting services on favourable terms (services such as gathering business, administering investments, adjusting claims, settling claims and arranging legal services).

While direct sellers have increased and continue to increase their share of the personal lines of property and casualty insurance in Ontario, direct sellers have not had a large percentage of this business in commercial lines and in liability insurance.

The Fundamental Equation

The central equation governing property and casualty insurance in Ontario is the same as that which applies everywhere else — that is:

$$\text{Premiums} + \text{Investment Income} = \text{Claims} + \text{Expenses.}$$

It follows, therefore, that to keep premiums low in relation to the service and claims provided, it is necessary to meet legitimate claims fairly and promptly with minimum expense.

It further follows that for a given level of claims and investment income, every dollar extra of expenses is a dollar extra of premium cost for insureds.

Expenses or transactions costs are far from being a trivial part of the premium dollar. Depending on the particular line of insurance, the averages range from 20% to 50%, with expenses for individual cases being both more or less of this range.

Expenses or transactions costs may well be excessive in relation to the level and quality of service provided. These expenses or transaction costs are myriad, and comprise:

1. The cost of acquiring insurance contracts by insurers, being brokers or agents' commissions, advertising and marketing and the cost of organizing and operating a sales network.

2. The cost of administering, monitoring and servicing insurance contracts.

3. The cost of identifying, determining and settling claims, including legal costs.

4. The cost of meeting regulatory requirements.

5. The cost of investment administration, which might be netted against investment income.

6. The cost of legal and other services to claimants, borne by claimants mainly out of claims or their own resources.

7. Court costs, partly borne by governments.

Some Important Details of the Structure in Ontario

In general, the property and casualty insurance industry provides two distinct types of coverage. By contract, they insure property against definable loss. By separate agreement or contract, they insure individuals, firms and corporations against liability, imposed by law, in connection with safe performance of goods and services provided by their named insured. The safe performance of such goods and services is determined by the appropriate courts, based on the principles of negligence as established under the common law and as modified by legislative enactments, such as the *Negligence Act*.

The one exception to this general division, with respect to liability insurance, is with regard to automobile insurance and the accident benefits coverage mandated by legislation and provided in all contracts. Accident benefits are a form of no-fault insurance, where covered persons are entitled to claim for medical rehabilitation and funeral expenses, death benefits, and loss-of-income payments. Accordingly, in this area there is a mixed no-fault/tort system whereby the innocent victim is entitled to certain direct payments forthwith from his own insurer. The amounts which he receives will be deducted from any award made by a court, where duplicate payments would result. This functions to provide a prompt payment system to the victim. It follows that the wrongdoer who is entitled to receive such no-fault payments does so regardless of his fault.

In all instances where the victim claims compensation or damages against a wrongdoer, redress must be had to the court system in Ontario, based upon the existing law of negligence. The wrongdoer who has protected himself and his assets by the purchase of insurance will be cognizant of the fact that this protection entitles him to a legal defence where appropriate, to be paid by his insurer, and also to indemnification to the extent of the limit, as provided in the insuring agreement. Up to the present time, the contractual limits of the policies have been readily attainable by the insured and, in practice, most brokers have been able to recommend and obtain limits that would satisfy the occurrences.

About 95% of claims made under insurance contracts in Ontario are settled without the necessity of the claimants engaging legal counsel. Of the remaining amount, many are settled prior to an actual trial, and only about 2% of all claims are decided by judicial determination of the appropriate court.

In Ontario, the Workers' Compensation Board, created under an act of the Ontario Legislature, handles all workers' claims against their employers. This is a distinct departure from the situation in the United States, where workers' compensation is a class of insurance sold by the private insurance industry. Its importance in Ontario is that professional drivers, who are entitled to receive workers' compensation benefits, are not entitled to claim for accident benefits under the standard automobile insurance contract. Further, their right of action against any wrongdoer is assumed by the Workers' Compensation Board, which claims on their behalf.

In addition, the Ontario Hospital Insurance Plan has a claim on behalf of any injured person who receives benefits under the Hospital Insurance Plan against a wrongdoer. In 1978, an agreement was arrived at between the automobile insurance industry and the Ministry of Health to avoid individual actions in each case, and to provide for bulk payment.

Certain features should be noted in connection with the provision of insurance to Ontario residents. These are:

1. **Farm Mutuals**
   Over 85% of farms in Ontario are insured by farm mutual insurance corporations. There are some 51 farm mutuals operating in Ontario, and many have been in existance over 100 years. They were created at a time when farmers had difficulty in

obtaining insurance or paying for what insurance was available. These farm mutuals are owned by their policyholders and over the years have developed their own reinsurance plan. Their powers have been extended to provide automobile insurance, and they also provide environmental protection to their members.

2. **Reciprocal Insurance Exchanges**

Reciprocal insurance exchanges may be created under the Ontario *Insurance Act*. Such an exchange is an unincorporated group or pool of individuals or organizations that contract with each other to spread the risk and losses inherent in their activities.

If one member suffers a loss, the others contribute toward the payment of that loss, based on a pre-agreed formula. The members, usually called subscribers, traditionally cover any losses by paying some premiums up-front and agreeing to be assessed for the amounts in excess of that premium. The exchange is accordingly a form of mutual insurance that can be attractive to certain groups of organizations that have certain activities in common. It is limited to property and casualty insurance.

Very few such organizations ever existed in Ontario, probably because of the ready availability of reasonable insurance.

There is increased activity in the formation of such exchanges at the present time.

3. **Pools**

During the current crisis, groups of insurers have banded together to form pools, in order to provide coverage on difficult-to-place liability risks. The first such pool was created in November 1985 to provide coverage under the newly proclaimed *Environmental Protection Act*. It is known as the Spills Pool and has over 20 subscribing insurers. The pool has a rate manual, and all subscribing insurers join in the insuring agreement.

In January 1986, because of difficulties in placing certain liability coverages, an additional pool was created. Its initial users were day care centres and tavern keepers. The amount of coverage is limited to $1 million. The pool is now known as the OLI Pool.

4. **The Facility Association**

The Facility Association came into being in 1980, with the advent of compulsory automobile insurance in Ontario. The principal purpose of the association is to guarantee market availability to any licensed driver in Ontario who could not obtain insurance through the ordinary market system. All licensed automobile insurers are members.

Insurance is placed through some 11 servicing carriers, who are licensed insurers. The rates charged for business placed are uniform. Coverages available are such as to ensure the availability of automobile insurance as required by law. In December 1985, the association, under special authority, undertook to permit limits for third-party liability of up to $5 million U.S., in order to permit special filing requirements of the United States Inter-State Commerce Commission with respect to Canadian carriers.

The association is a non-profit organization, and its losses are borne by all licensed insurers.

The primary users of the Facility Association have been high-risk drivers. Where premiums collected from those insured are less than the cost of providing the insurance and claims, it can be stated that these insureds are receiving a subsidy. For liability coverage, the amount of this subsidy in 1984 was $512.54.

5. **Captives**
   Some of the larger businesses in Canada have created captive insurance companies. These arrangements for corporations and their affiliated companies permit the placing of insurance for corporate needs. Except for automobile insurance, which must be placed with licensed insurers, any person in Ontario is free to purchase insurance outside the province, for his own needs. The advantage to the insured is obvious, in that there is ability to structure a tailor-made insurance program and capacity that can be insured. Premiums remain a deductible expense in doing business. In several American states and in a number of offshore countries, such as Bermuda, there is special legislation which recognizes that certain insureds do not need the regulatory protection offered to the general public. In most instances, the usual insurance-type investment clauses are not applicable. An additional attraction is that the income earned on investments by the captive insurer may not attract tax in the domicile of the parent company.

   Where captive insurers insure other third parties, it is customary to do so by a reinsurance arrangement with a fronting, licensed insurer.

6. **Self-Insurance**
   Many corporations retain the responsibility for their risks by establishing self-funded reserves. In such instances, corporations endeavour to retain the portion of the risk compatible with their own risk-bearing capacity. In short, they settle their own claims out of their own funds. In most instances, they provide for a form of excess insurance for losses sustained over a certain amount with a licensed insurer.

Insurance Industry Associations

As noted, the public in Ontario primarily deals with the insurance industry through agents and brokers. The majority of Ontario insurance brokers voluntarily belong to either the Insurance Brokers' Association of Ontario or the Toronto Insurance Conference. More than 1,250 brokerage firms are members of the two associations. Over 8,500 insurance brokers and support staff are employed by these firms.

With regard to insurers in the property and casualty insurance business, there is a history of special organizations — in the sense that bureaus were originally recognized and organized along provincial lines, with the purpose of designing suggested insurance contracts; settling rules, regulations and rates; and defining risks. The original organization was the Canadian Underwriters' Association. A number of independent conferences or bureaus also existed with respect to what were known as the non-tariff insurers, which were represented by the Independent Insurance Conference. In July 1974, the CUA and the IIC joined forces to form the Insurers' Advisory Bureau of Canada, which is now the principal advisory rating bureau in Canada.

The major insurers' organization is the Insurance Bureau of Canada, which operates as an umbrella organization for most insurers in Ontario and Canada.

The Insurance Crime Prevention Bureau, as maintained by its member insurance companies, provides effective co-operation to police and fire authorities in the detection, investigation and prosecution of insurance crime.

Details of all three organizations are attached as an Addendum hereto.

Regulatory Framework and Principles

Legislative intervention by several provincial governments occurred before Confederation, in connection with the formation and affairs of mutual fire insurance companies, as well as to regulate fire insurance companies.

However, no specific mention of the subject of insurance appeared in the *Constitution Act* of 1867. As a result, there were numerous disputes between the federal and provincial authorities, which were resolved in a series of judicial decisions ending in 1931. The latter years of this century have been characterized by regulatory co-operation.

In 1868, the federal Parliament began to legislate with respect to incorporation of individual companies, solvency and investment of insurance funds. As a result of the report of a Royal Commission, Ontario enacted legislation with respect to uniform conditions and policies of fire insurance in 1876.

In 1932, the federal Parliament passed the *Canadian and British Insurance Companies Act*, the *Foreign Insurance Companies Act*, and the *Department of Insurance Act*. These Acts excluded previous federal provisions with respect to the conditions of insurance contracts and concentrated on matters relating to the solvency of companies registered under the federal Acts.

In general terms, the federal government now concerns itself almost exclusively with the financial soundness of non-Canadian companies and of Canadian-incorporated companies which are registered federally. The provincial authorities concern themselves with their own incorporated insurers and all other insurance matters.

Insurance regulation by the governments of Canada may be categorized as promoting:

1. the financial solvency of insurers;
2. the viability of the insuring contract; and
3. the honesty and competence of insurance intermediaries.

All provinces and territories, as well as the federal government, have Superintendents of Insurance whose major focus has been the financial soundness of insurers. In addition to legislation and regulation, guidelines or directives are issued by the superintendents with respect to the conduct of the business of insurance.

A large degree of uniformity has been achieved in multiple licensing reporting and investment requirements. In general, the provinces rely on the supervision of the federal Department of Insurance over all federally registered insurers in connection with solvency.

The large degree of uniformity has been achieved, to a large part, by the Association of Superintendents of Insurance, now known as the Canadian Council of Superintendents of Insurance.

This association originated in a meeting in Western Canada by the four western provinces in 1914. Ontario entered in 1915, and in 1917 the association was organized. Quebec entered in 1921. New Brunswick, Nova Scotia and Prince Edward Island joined in the 1930s. Newfoundland joined in 1952, and the Northwest Territories and Yukon Territory joined in the 1970s. At the present time, the council has a permanent office in Ontario, and its administrative functions are performed by the Ontario superintendent's office.

The council continues the function of the Uniform Law Conference in relation to insurance matters and proposed uniform legislation. It is a forum for discussion of common regulatory matters and co-operation between regulators. It has also issued standard guidelines to govern the conduct of the business in certain areas.

The council continues to meet twice yearly, once in April (an executive session) and once in the fall (a public session, where it invites submissions from the industry and the public). The council is not an administrative tribunal with rule-making authority over the industry. By reason of the fragmentation of the property and casualty industry and the number of companies operating, it is fundamental, however, that the companies be represented by strong industry associations.

History of the Development of the Structure of the Property and Casualty Insurance Industry — A Thumbnail Sketch

Many of the larger stock or mutual federally licensed insurers are active across Canada. The ten largest general primary insurers in Canada write business in all ten provinces and the territories. Seven of these insurers are among the ten largest writers of insurance in Ontario. Of the others, the Pilot Insurance Company writes only in Ontario and is provincially licensed, State Farm Insurance Companies are active in Ontario and in three other jurisdictions, and the Zurich Insurance Company writes business across Canada, but with over 60% of its business originating in Ontario. Both State Farm and Zurich are federally registered companies.

Three of the ten largest insurers in Ontario are direct writing companies; the remainder operate throught the broker/agency distribution system.

The greatest contrast with Ontario is the structure in Quebec, where three of the four largest insurers are Quebec-based companies, each of which writes a preponderance of its business in that province. Together, they and other similar insurers are responsible for over 30% of all premiums written in that province.

Automobile Insurance. Automobile insurance is compulsory in all the provinces and territories. In Ontario, as well as in Newfoundland, Prince Edward Island, Nova Scotia, New Brunswick, Alberta, the Yukon, and the Northwest Territories, automobile insurance is the responsibility of private insurers.

In Quebec, bodily injury coverage is written through La Régie de l'assurance and is the responsibility of the provincial government. Coverage is written on a no-fault basis, as is property damage liability insurance, which remains the responsibilty of private insurers.

Three western provinces - British Columbia, Saskatchewan and Manitoba - have mandatory insurance through provincial government programs. Coverage provided under these programs is not available through the private sector. Optional coverages may be purchased through either government corporations or private insurers.

Other Insurance. In Manitoba, the Manitoba Public Insurance Corporation, and in Saskatchewan, the Saskatchewan Government Insurance write other lines of insurance, in direct competition with the private sector. Both of these corporations are the largest single general insurers in their respective provinces. In British Columbia, the general insurance business carried on by the Insurance Company of British Columbia was sold to a private carrier in 1984, and the provincial corporation is now restricted to automobile insurance.

Farm mutuals are provincially licensed in Ontario and operate basically in limited geographic areas of the province. Similar companies are also active in a number of other provinces.

Newfoundland and New Brunswick each have a number of small, provincially licensed companies which collectively, in the case of Newfoundland, write a significant percentage of the premiums generated within the province.

ADDENDUM — INDUSTRY ASSOCIATIONS

Insurance Bureau of Canada

The **Insurance Bureau of Canada** was formed in 1964 as the official voice of Canada's private sector property/casualty insurance companies. IBC is concerned with all classes of insurance except life, hail, accident and sickness, and ocean marine.

More than 100 insurance companies and groups, representing in excess of 80% of private industry insurance premiums, are provided, through membership in IBC, with programs and services.

One of the many functions of the **Information Systems Division**, located in Don Mills, is to receive and process the statistical information provided by every private sector company writing automobile insurance in Canada. Statistical exhibits ("Green Book") are compiled semi-annually for publication and distribution to the Superintendents of Insurance and the insurance industry.

Premium and loss data, as defined in the Personal Lines and Commercial Lines Statistical Plans, are collected from member companies for annual production of the "Brown Book" and the "Red Book".

Judgment Recovery uses the information system for disposition of unsatisfied judgment claims. The system provides quarterly and annual assessments to insurers for the operation of the Unsatisfied Judgment Funds (Nova Scotia, Prince Edward Island and Newfoundland).

The Information Systems Division operates as a service bureau to the Facility Association and to the Groupement des assureurs automobiles (GAA). Semi-annual automobile accident-year statistical exhibits are produced for the province of Quebec.

Facilities managment services are provided to the Insurance Crime Prevention Bureau (ICPB), which provides to IBC-ICPB members information related to fraudulent or suspicious insurance losses, as well as automobile theft and salvage.

The **Communications Division** has responsibility for much of the two-way communication with IBC's many publics, both internal and external.

The division develops and implements a broad communications and advertising program designed to benefit the total general insurance industry and consumers of its services. This program has several objectives:

- to educate consumers to be informed buyers;
- to foster an appreciation of merits of the present private sector insurance system, including competitive pricing and service, and freedom of choice;
- to promote loss reduction and loss prevention; and
- to monitor all aspects of the social, political and economic environment as they may affect the general insurance industry, to analyze this information, and to take appropriate action.

The **Insurance Operations Division** is made up of five distinct departments:

1. **Actuarial and Statistical Services**
   The role of the Actuarial and Statistical Services Department is essentially four-fold:
   - It controls the content of the IBC Statistical Plans for Personal Lines and Commercial Lines under which members report their statistics to IBC. It also is responsible for the implementation of all changes to the Superintendents' Statistical Plan for Automobile Insurance, under which all automobile insurers are required to report their statistics (outside of Quebec) to IBC.
   - It contributes factors calculations to and reviews the major All Industry/All Member and Individual Company Statistical Exhibits ("Green Book" — Automobile; "Brown Book" — Personal Lines; "Red Book" — Commercial Lines) of the experience collected under the various statistical exhibits and may produce trial versions of new exhibits while they remain in the design stage.
   - It is charged with the responsibility of seeing to it that controls are put into place to produce a reasonable level of quality both in the data submitted to and the statistical exhibits produced by IBC.
   - It spends much of its time engaged in liaison. It works closely with the Data Centre Department with regard to Statistical Plan changes, problems with data submitted by companies, and exhibit production, and with the Development Centre Department with regard to systems and programming which support the transformation of raw data to statistical exhibits.

2. **Claim and Field Services**

This department is responsible for the administration of claims-related services, as follows:

- Establishing a network of IBC-approved damage appraisal centres which are customer convenience, cost controlled and give a fair appraisal of damage.

A network of appraisal centres owned and operated by independent businessmen is in place in Newfoundland, Nova Scotia, New Brunswick, Ontario and Alberta.

Through reinspection of appraisals before, during and after repairs by both appraisal centre staff and IBC staff, the quality of appraisals is maintained throughout the network. IBC staff and appraisal centre staff are also directly involved in I-CAR (Inter-Industry Conference on Automobile Collision Repairs), effectively promoting training in and understanding of evolving automobile repair techniques.

Each appraisal centre utilizes the Audatex computer system to assist in the preparation of appraisals. Through pre-stored part numbers/prices and replace/refinish labour times, the accuracy of the appraisal is greatly enhanced, eliminating mathematical errors, overlaps/included operations and incorrect part prices.

IBC staff maintains close dialogue with Groupement des assureurs automobiles, which administers a network of appraisal centres in Quebec following similar policies and principles.

IBC is responsible for the co-ordination of the development of the Industry Claims Emergency Response Plan and for the administration of the plan in the event of an emergency.

3. **Economic Research Department**

- Contributes to the Bureau's strategic planning and committee activity by providing inputs in the form of economic studies, market research and statistical interpretations.
- Co-ordinates the activities of the Financial Analysis Committee and its subcommittees, the Panel on Taxation, the Executive Data Processing Committee, the User Service Committee and the Directors' Ontario Advisory Committee.

It generates financial/accounting industry exhibits including the Expense Allocation and Reporting Program Results, Analysis of Profit and Loss of Canadian Business by Major Class, Provincial Allocation of Investments, and a quarterly analysis of Statistics Canada estimates of industry results. Monitoring of external trends includes the release of the Canadian Crash Parts Price Index, and interpretations of the quarterly Omnibus Public Opinion Survey.

4. **Insurance Services Department**

Provides full-time technical and administrative support to various committees where underwriting criteria, contract wordings, claims practices and consumers' affairs can be studied and appropriate recommendations for improvements made. It is at the committee level that any basic changes to insurance contracts are first considered and, as desirable, implemented. Developments related to the prompt settlement of claims via inter-company agreements are usually initiated by the company representatives who make up the committees.

The work of the five product-line committees and the Claims Committee, composed of senior company executives, is co-ordinated by the Department:

- The Personal Lines Committee is responsible for the development and maintenance of the Clear Language Habitational Forms Program. It administers and oversees the IBC Home Evaluation Program, which provides members and policyholders with a system for estimating the cost of rebuilding a home.

- The Commercial Property Committee reviews and develops commercial property forms which are recommended for use to the member companies. One of its other major responsibilities is the management of the Property/Boiler Disputed Loss Agreement.
- The Liability Committee reviews and develops commercial liability forms which are promulgated for use by member companies. The committee monitors court awards and legislation covering subjects related to health and environmental concerns, responding to the needs of policyholders.
- The Automobile Committee assists and advises Superintendents of Insurance on subjects such as automobile insurance legislation and forms. As well, the committee oversees studies of major importance to the industry such as the Automobile Classification Study.
- The National Surety Committee regularly reviews reports from its five regional committees to monitor changing market conditions and legislation across Canada. An important role of this committee is liaising with governments and industry associations to explain the role of suretyship and encourage the development of acceptable bond forms and practices. Through the efforts of its Claims Sub-Committee, a Surety Claims Code of Ethics was developed for the guidance of member surety writers.

The department is also responsible for co-ordinating the activities of the Claims Committee, which reviews and approves forms and guidelines that make up the Agreement Respecting Standardization of Claims Forms and Practices. It is involved with the administration of the IBC Claims Emergency Response Plan, the Agreement of Guiding Principles with Respect to Overlapping Coverages Relating to Property Insurance and the Agreement of Guiding Principles Between Primary and Excess Liability Insurers Respecting Claims.

An important function of the department at Head Office is to provide a communication link through the Consumer Liaison Officer for enquiries from consumers on a wide range of topics related to policy coverages and claims settlements.

- Fire Underwriters Survey is a national organization financed by IBC. Through the Insurance Services Department, members are provided with data on the status of public fire protection in all areas of Canada for fire insurance classification purposes, developed by FUS.

  Fire Underwriters Survey also assists municipalities in improving the ability of their fire departments to fight fires and better deal with fire protection and prevention problems.

5. Legal Division

The Legal Division maintains contacts with senior civil servants in the various provinces and territories and at the federal level. In particular, close contact is maintained with the Ministries of Justice, Consumer and Commercial Relations, Transportation and Communications, and Environment and, of course, with the various Superintendents of Insurance and Legislative Counsel. Through these contacts and through appearances before Select and Standing Committees of provincial legislatures and the federal Parliament, the Legal Division seeks those changes in the law which best serve the industry or lessen any adverse impact on the industry. Member companies are regularly informed by bulletin of changes in the law which may affect them in any way.

Members of the Legal Division regularly take part in the work of standing committees set up by the Association of Superintendents of Insurance of the

Provinces of Canada and are frequently requested to respond to position papers by various public bodies such as Law Reform Commissions, etc.

The Legal Division keeps a very close watch on judicial interpretations of insurance contracts and takes to appeal those cases of general application where the court decision is not in accord with the spirit of the law or the intent of the contract. Where necessary, amendments to either the law or the contract are recommended to achieve the desired objectives.

In co-operation with the other Divisions of IBC, the Legal Division helps in the development, interpretation and revision of policy wordings; the drafting of industry agreements; and the preparation of responses to governments and other public bodies on all important issues.

With a staff complement of 140, the Bureau maintains its head office in downtown Toronto and the Don Mills location, where the information systems, claims and field services, and actuarial and statistical functions are located, and has regional offices in the Atlantic Provinces, Quebec, the Prairies and on the west coast.

Insurers' Advisory Organization of Canada

Insurers' Advisory Organization of Canada, formerly known as the Canadian Underwriters' Association, is a voluntary, non-profit organization funded by 52 groups of general insurance companies who underwrite more than 50% of the fire and casualty insurance business in Canada. Through its predecessors, the IAO can trace its history back to 1855 when the first Association was established.

IAO supplies its members with technical services which can be broadly defined as:

Loss Prevention and Control — services which prevent or minimize loss, including fire protection, safety, security and loss control engineering; individual risk inspection; public fire protection surveys; and operation of a School of Loss Control Technology.

Risk Evaluation — services which develop the information needed by insurers to determine premium levels which reflect variations in the degree of risk or hazard.

IAO actuaries and rating staff develop statistical plans supplementary to the loss and expense statistical plans developed by the Insurance Bureau of Canada. The IAO plans contain the more detailed and refined data needed for rate-making.

By analyzing and interpreting statistical exhibits and by applying actuarial and rate-making techniques, IAO actuaries and rating staff develop advisory rate schedules for commercial property lines as well as advisory premium tables for habitational lines, personal and commercial automobile, crime coverages, general liability and employers' liability, glass, forgery, fidelity and surety (guarantee).

Where required, the IAO files its advisory rating programs with provincial regulatory authorities.

Services are provided by a staff of 500 people who are located in a network of 29 offices, stretching from coast to coast.

Insurance Crime Prevention Bureau

The **Insurance Crime Prevention Bureau** is a non-profit organization maintained by member insurance companies to provide effective co-operation to police and fire authorities in the detection, investigation and prosecution of insurance crime.

The bureau operates with the following branches:

- Fire Underwriters' Investigation Bureau;
- Canadian Automobile Theft Bureau; and
- Casualty Claims Index Bureau.

The main purpose of the Insurance Crime Prevention Bureau is to protect the public, insurance consumers and the insurance company from the ever-increasing cost of crime.

The bureau investigates:

- insurance crime, such as arson or faked burglaries, where the motive is fraudulent collection of insurance money; and
- insurance-related crime, motor vehicle theft and vandalism for example, where the motive varies but insurance loss is the result.

Operating throughout Canada, the **Fire Underwriters' Investigation Bureau** concentrates on crime associated with fire losses or fraudulent property insurance claims. With the continued infiltration of organized crime into legitimate business, these investigations have become extremely complex and are occupying much of the bureau's time and resources.

The **Canadian Automobile Theft Bureau** is fully operational in all provinces where private/independent insurers do business. CATB is concerned with criminal rings which steal motor vehicles for resale or for parts stripping, in addition to investigating suspicious individual thefts and vehicle burnings where fraud may be involved.

The **Casualty Claims Index Bureau** records all bodily injury claims (whether automobile or other liability) and all accident benefit claims where the disability is known or predicted to be in excess of four weeks.

The Bureau employs more than 70 special agents, each with at least eight years' policing experience prior to joining the staff. Special recruitment attention is given to candidates with extensive investigative background and experience in courtroom procedures.

APPENDIX 6

MANDATORY INSURANCE LEGISLATION IN ONTARIO AND CANADA

Mandatory Insurance Provisions — Statutes of Ontario

Ambulance Act
R.S.O. 1980, c.20
— paragraph 22(1)(b) (regulation-making authority)
— section 23 (offence provision)
— R.R.O. 1980, Reg.14, Part VII

Amusement Devices Act, 1986 (Royal Assent, January 17, 1986)
R.S.O. 1986, Bill 97, c.6
— section 4 (and regulations)

Architects Act, 1984
S.O. 1984, c.12
— paragraph 7(1)25 (regulation-making authority)
— paragraphs 8(1)24 and 25 (by-law-making authority)
— sections 39 and 40
— O.Reg.517/84, sections 35-40

Compulsory Automobile Insurance Act
R.S.O. 1980, c.83
— section 1 (definitions)
— section 2

Condominium Act
R.S.O. 1980, c.84
— subsections 27(1) and (5)
— section 49 (offence provision)

Education Act
R.S.O. 1980, c.129
— section 149.9

Grain Elevator Storage Act, 1983
S.O. 1983, c.40
— section 19
— section 25 (offence provision)

Local Services Board Act
R.S.O. 1980, c.252
— subsection 7(5)

Motorized Snow Vehicles Act
R.S.O. 1980, c.301
— section 11, as amended by S.O. 1982, c.13, subsection 4(3)

Off-Road Vehicles Act, 1983
S.O. 1983, c.53
— section 1 (definitions)
— section 15

Pesticides Act
R.S.O. 1980, c.376
— section 9
— section 37 (offence provision)
— R.R.O. 1980, Reg.751, section 19

Power Corporation Act
R.S.O. 1980, c.384
— section 1 (definitions)
— section 2 (application)
— section 97
— sections 101 and 103 (offence provisions)
(See also:
Power Corporation Insurance Act,
R.S.O. 1980, c.385, which does not contain mandatory provisions)

Professional Engineers Act, 1984
S.O. 1984, c.13
— paragraphs 7(1) 24 and 26
— sections 35 and 36
— O.Reg. 538/84, section 88

Public Commercial Vehicles Act
R.S.O. 1980, c.407
— section 1 (definitions)
— section 28
— section 35, as amended by S.O. 1981, section 14 (offence provision)

Public Vehicles Act
R.S.O. 1980, c.425
— section 1 (definitions)
— section 27
— section 32 (offence provision)

Mandatory Insurance Provisions — Regulations of Ontario

Children's Residential Services Act
R.S.O. 1980, c.71
O.Reg.28/83
— section 21

Commodity Futures Act
R.S.O. 1980, c.78
R.R.O. 1980, Reg.114
— section 20

Conservation Authorities Act

- R.S.O. 1980, c.85
- R R.O. 1980, Reg.125 (Catfish Creek)
  - — subsection 16(4)
- R.R.O. 1980, Reg.127 (Credit Valley)
  - — subsection 19(5)
  - — paragraph 19(7)(a)
- R.R.O. 1980, Reg.128 (Crowe Valley)
  - — subsection 21(3)
- R.R.O. 1980, Reg.129 (Essex Region)
  - — subsection 21(3)
- R.R.O. 1980, Reg.130 (Ganaraska Region)
  - — subsection 16(3)
- R.R.O. 1980, Reg.131 (Grand River)
  - — subsection 16(4)
- R.R.O. 1980, Reg.134 (Kettle Creek)
  - — subsection 16(4)
- R.R.O. 1980, Reg.136 (Lower Thames Valley)
  - — subsection 15(5)
- R.R.O. 1980, Reg.137 (Maitland Valley)
  - — subsection 16(4)
- R.R.O. 1980, Reg.138 (Mattagami Valley)
  - — subsection 18(4)
- R.R.O. 1980, Reg.140 (Napanee Region)
  - — subsection 16(3)
- R.R.O. 1980, Reg.141 (Niagara Peninsula)
  - — subsection 16(4)
- R.R.O. 1980, Reg.144 (Otonabee Region)
  - — subsection 21(3)
- R.R.O. 1980, Reg.145 (Prince Edward Region)
  - — subsection 16(4)
- R.R.O. 1980, Reg.146 (Rideau Valley)
  - — subsection 16(4)
- R.R.OP. 1980, Reg.147 (St. Clair Region)
  - — subsection 16(3)
- R.R.O. 1980, Reg.148 (Sauble Valley)
  - — subsection 16(4)
- R.R.O. 1980, Reg.150 (Sault Ste. Marie Region)
  - — subsection 18(4)
- R.R.O. 1980, Reg.151 (South Lake Simcoe)
  - — subsection 16(4)

Day Nurseries Act

- R.S.O. 1980, c.111
  - — O.Reg. 760/83, subsections 26(a) and (b)

Legal Aid Act

- R.S.O. 1980, c.234
- R.R.O. 1980, Reg.575
  - — section 36

Livestock Community Sales Act

R.S.O. 1980, c.247

R.R.O. 1980, Reg.586

— subsection 5(a)

Milk Act

R.S.O. 1980, c.266

O.Reg. 442/81

— subsection 27(a)

Niagara Parks Act

R.S.O. 1980, c.317

R.R.O. 1980, Reg.686

— paragraph 13(5)(d)

— section 15

Petroleum Resources Act

R.S.O. 1980, c.377

R.R.O. 1980, Reg.752

— subsection 27(2),(3),(4)

Registered Insurance Brokers Act

R.S.O. 1980, c.444

O.Reg. 637/81

— section 21

Securities Act

R.S.O. 1980, c.466

R.R.O. 1980, Reg.910

— section 96

St. Clair Parkway Commission Act

R.S.O. 1980, c.485

R.R.O. 1980, Reg.906

— subsection 12(4)

St. Lawrence Parks Commission Act

R.S.O. 1980, c.486

R.R.O. 1980, Reg.909

— subsection 9(b)

Mandatory Insurance Provisions — Statutes of Canada

Aeronautics Act

R.S.C. 1970, c.A-3

— paragraph 14(1)(j)

— section 16 (offence provision), as amended by S.C.1976-77, c.26, subsection 4(2)

— C.R.C. 1978, c.3, paragraph 20(1)(c)

— S.O.R./78-689 (adding 17.1)

— S.O.R./80-745 (amending section 17.1)

— S.O.R./81-953 (adding section 14.1)

- S.O.R./83-166 (amending paragraph 20(2)(a))
- S.O.R./83-443 (adding Part 11.1)
- S.O.R./84-903 (adding section 12.1)

Canada Grain Act
S.C. 1970-71-72, c.7
- subsections 36(1) and (2)
- paragraph 98(1)(k) (regulation-making provision)
- C.R.C. 1978, c.889, section 22

Canada Shipping Act
R.S.C. 1970, c.S-9, as amended by S.C. (2nd Supp.), c.27
- section 736 (which refers to sections 734 and 735)
- subsection 753(1) (offence provision)

Merchant Seamen Compensation Act
R.S.C. 1970, c.M-11
- section 29

Nuclear Liability Act
R.S.C. 1970, (1st Supp.), c.29
- sections 15 and 16

Mandatory Insurance Provisions — Regulations of Canada

Arctic Waters Pollution Protection Act
R.S.C. 1970, c.2 (1st Supp.), as amended

Arctic Waters Pollution Prevention Regulations
C.R.C. 1978, c.354
- subsection 12(1)

Athletic Contests and Events Pools Act and Criminal Code
S.C. 1980-81-82-83, c.161 and R.S.C. 1970, c.C-34, respectively, as amended

Games Regulations
S.O.R./84-350, May 1, 1984
- section 2 (definitions)
- subsection 14(1)

Sports Pool Systems Regulations
S.O.R./84-326, April 19, 1984
- section 2 (definitions)
- subsection 14(1)

Criminal Code
R.S.C. 1970, c.C-34, as amended

National Lottery Regulations
C.R.C. 1978, c.431
- subsection 15(1)

S.O.R./78-681, August 24, 1978
(which amended c.431, *inter alia*, by adding Part II re Lotto Select)
— subsection 36(1)

Cooperative Credit Associations Act
R.S.C. 1970, c.C-29, as amended

Protection of Securities (Cooperative Credit Associations) Regulations
C.R.C. 1978, c.420
— subsections 2(1) (definitions)
— paragraphs 9(1)(a),(b),(c),(d)

Canadian and British Insurance Companies Act
R.S.C. 1970, c.I-15, as amended

Protection of Securities (Insurance Companies) Regulations
C.R.C. 1978, c.980
— subsection 2(1) (definitions)
— paragraphs 9(1)(a),(b),(c),(d)

Loan Companies Act
R.S.C. 1970, c.L-2, as amended

Protection of Securities (Loan Companies) Regulations
C.R.C. 1978, c.1031
— subsection 2(1) (definitions)
— paragraphs 9(1)(a),(b),(c),(d)

Trust Companies Act
R.S.C. 1970, c.T-16, as amended

Protection of Securities (Trust Companies) Regulations
C.R.C. 1978, c.1568
— subsections 2(1) (definitions)
— paragraphs 9(1)(a),(b),(c),(d)

St. Lawrence Seaway Authority Act
R.S.C. 1970, c.S-1, as amended

Seaway Regulations
C.R.C. 1978, c.1397, amended by S.O.R./80-256, April 8, 1980
— section 23

Livestock and Livestock Products Act
R.S.C. 1970, c.L-8, as amended

Stockyards Regulations
C.R.C. 1970, c.1025
— section 9

APPENDIX 7

TRENDS AND CYCLES, AVAILABILITY, PRICE, AFFORDABILITY, FINANCIAL PERFORMANCE

Prepared by
Coopers & Lybrand

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TRENDS AND CYCLES, AVAILABILITY, PRICE, AFFORDABILITY, FINANCIAL PERFORMANCE

Introduction and Summary

This Appendix presents a review and discussion of the following issues in the property-casualty industry in Canada, in general, and in Ontario, in particular: trends and cycles, availability, price, affordability, and financial performance. This discussion essentially summarizes the analysis and conclusions drawn from three studies undertaken by Coopers & Lybrand and another by The Wyatt Company for the Task Force on Insurance.[1]

The principal conclusions from the four broad sections of this Appendix can be summarized as follows:

Section 7.1

- There is sufficient current capacity in the property-casualty industry to meet any reasonable growth in *general* demand for insurance services for the forseeable future.
- Capacity constraints or unavailability problems are localized to particular lines of business (primarily liability insurance) and, therefore, require specific and focused solutions.
- The property-casualty insurance industry in Ontario recently experienced the trough of its business cycle, characterized by capacity contractions and large price increases. Although the cyclical recovery is already underway, certain structural problems will persist, such as in liability insurance.
- Reinsurers have remained loyal in providing general capacity to the market. Capacity problems, however, are confined to particular areas.
- There has been a history of premium inadequacy in the property-casualty industry. Over the last six years, premium rates for a wide range of lines have averaged *real declines* of between 2.0% and 5.0%, annually.

Section 7.2

- Personal insurance costs are minor budgetary items for the average family in Canada. Nevertheless, sharp increases in personal insurance premiums have stretched those on tight budgets.
- Liability insurance costs represent a negligible component of the total municipal tax base and the total provincial hospital operating budget in Ontario, respectively. Disruptions in their budgeting process were caused by unanticipated and large premium increases and unavailability of coverage for certain cases.

Section 7.3

- Return on investment is volatile and has generally been below returns achieved by other industries.
- The investment returns achieved by the Ontario insurers are consistently below the rate of return achieved by investing in Canadian midterm corporate bonds.
- There is a marked deterioration in the liability direct loss ratio from 1981 to 1984.
- The automobile direct loss ratio has deteriorated significantly since 1982.
- Expenses of Ontario insurers as a percentage of earned premiums are higher than the United States and provincial government insurers.

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[1] The three papers undertaken by Coopers & Lybrand for the Task Force on Insurance are titled: "Review of Trends and Cycles in Availability and Price of General Insurance Services"; "The Financial Performance of the Property-Casualty Industry"; and "Summary Paper: Causes and Prospects for the Current Cycles in Availability and Price, Financial Performance and Reserve Experience in the General Insurance Industry". The paper by The Wyatt Company is titled "An Overview of Methods and Estimates of Claim Reserve Liabilities for the Property-Casualty Industry".

- Insurers are dependent on investment income to offset underwriting losses and earn a profit. There has not been an underwriting profit during the period 1978 to 1984.
- The high level of retention of profits has provided the solvency and financial backing for the industry over the last decade.
- The industry is generally solvent and liquid; solvency would appear to have improved since 1981.
- Claims reserves represent a significant portion of an insurance company's financial structure and have experienced a marked increase during 1984 that was centred on commercial liability reserves.
- Claims reserves stated on the 1984 financial statements were approximately $956 million deficient (18.7% of stated reserves) on a non-discounted basis.
- The most prevalent cause for insurance company failure is the relationship of an insurer with related companies, either by way of management agency contracts or reinsurance, resulting in liquidity problems.
- The Canadian reinsurance industry is solvent and profitable; however, certain *deviations* from this norm may occur in *specific business lines* within individual companies.

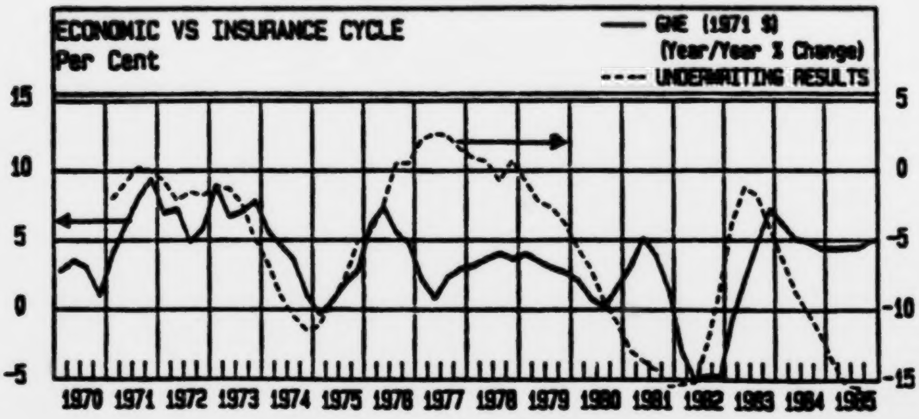
Section 7.4

- Large claims do not appear to be, in themselves, a reason for rapid increases in overall automobile-related claims.
- Whereas the frequency of claims has largely declined over the period 1981-1985, the average cost per claim has risen substantially and is the critical factor underlying overall automobile claims growth in Ontario.
- The fairly stable relationship observed between general expenses and net earned premiums over the period 1978-1984 suggests a stagnant productivity situation.
- Insurers pay a high proportion of total revenue as commission to agents on acquisition of premiums.
- There has been a marked rise in reinsurance costs in most lines and substantial increases in certain lines where residual reinsurance is still offered.
- There appears to be little further capacity in foreign markets for liability risks, particularly emanating from North America.
- The competitive structure of the industry and the peculiarity of its distribution system explain the excessively competitive pricing policies and the lags in response evident in the price-cost-performance relationship.
- The recent cyclical downturn in the property-casualty industry was exaggerated by a series of shocks that have impeded the inherent self-corrective mechanisms in the industry that usually work towards alleviating cyclical problems.

7.1 A Description and Analytical Review of Trends and Cycles in Availability and Prices of Various General Insurance Services

The business cycle experience measured by changes in real Gross National Expenditure (GNE) on a national basis does not convey the wide divergence in the cyclical experience of particular sectors and the provinces. The property-casualty insurance industry in Canada and in Ontario, in particular, does experience, as do most other industries, cyclical fluctuations in performance.

CHART 1



Source: Statistics Canada, *Financial Institutions*, Cat. No. 61-006 and *National Income and Expenditure Accounts*, Cat. No. 13-001.

However, these cycles (measured by underwriting results, which are defined as the underwriting gain/loss as a percentage of earned premiums) have not conformed closely with the economic cycles observed and, in recent times, the magnitude of the downcycle has been particularly pronounced and prolonged. Furthermore, while the benefits of the economic recovery since the end of 1982 have spread to some degree into most industries, there is little evidence of such a development taking hold in the property-casualty industry. In fact, the underwriting experience and income performance has steadily deteriorated over the last three years.

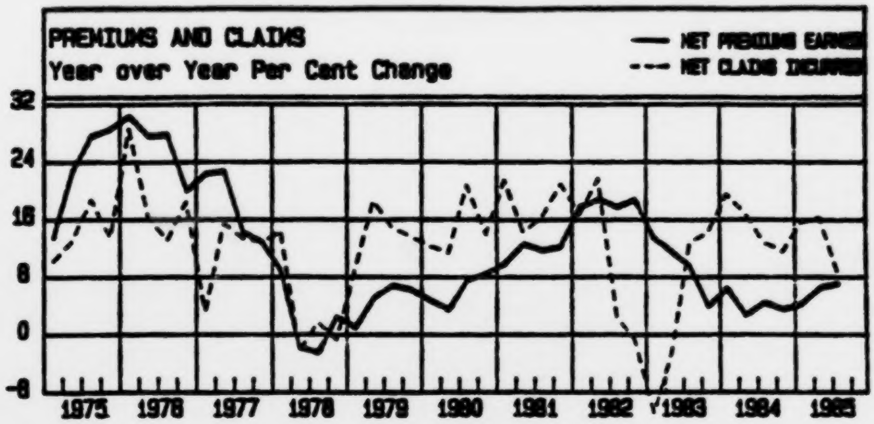
Clearly, a set of external and internal forces are at play that serve to exaggerate the frequency and amplitude of the "normal" business cycle observed in the property-casualty industry. There appears to be a growing dissonance between the dynamics in the industry and macro-economic developments that have led to an accentuated downturn in the industry in Canada. Also contributing to the recent unfavourable trends is the general downtrend in world insurance markets and emerging capacity constraints in certain segments of international reinsurance markets.

The severe downcycle the industry has experienced has aggravated and focused public attention on some critical structural issues. The normal innovative experience of the industry and the inherent self-corrective mechanisms in the market have been hindered by the severity of the downturn in dealing effectively with these issues. Furthermore, the normal ability of the cyclical upswing to alleviate structural problems is now uncertain as some significant changes to market structure and institutions have now surfaced. It is our understanding that although cyclical issues will ease, structural problems will persist in the following areas: liability insurance; environmental pollution insurance; products liability insurance; professional liability insurance; and coverage for the voluntary sector.

Premiums and Claims Experience in Canada

One of the principal reasons the industry finds itself in its current problems is that premium growth has not been sufficient to cover the rapid increases in claims incurred. Over the period 1975 to the third quarter, 1985, net premiums earned averaged a compound growth rate of 10.7% to a level of $8.3 billion. In contrast, net claims incurred averaged a compound growth rate of 11.7 % to a current level of $6.4 billion.

CHART 2



Source: Statistics Canada, *Financial Institutions*, Cat. No. 61-006.

During the last ten-year period, however, premiums and claims experienced two complete business cycles. In fact, the third business cycle has been underway since the early part of 1985. During 1984, claims increased by 15.2%, while premiums expanded by only 4.1%, thereby lending a sense of urgency to the current situation. The first quarter of 1985 saw premium growth pick up smartly, whereas claims growth during the third quarter of 1985 started to converge with that of premiums for the first time during the previous eight quarters. The continuation of these trends will contribute, in part, to the alleviation of the current state in the insurance industry.

Capital Utilization and Excess Capacity

The concept of capacity in the general insurance industry is nebulous, reflecting more an attitude adopted by insurers rather than physical or purely financial capability. In essence, capacity in the industry is the *supply* of *willingness* to assume risks, which is determined by the following factors:

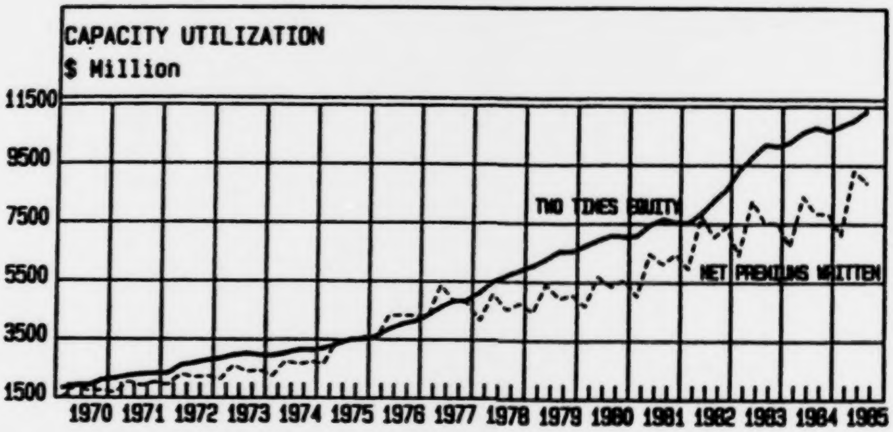
- the equity (capital and surplus) position of the industry;
- the relationship between the actual claims experience and expected value of claims based on developments in the frequency and size of settlements;
- actual investment income relative to expected earnings;
- the level of expenses incurred relative to that anticipated; and
- the risk assessment in particular lines of business, which is determined not only by the claims experience but by broad environmental and judicial (settlement awards) developments.

Thus, a review of cycles and trends in capacity, on an industry-aggregate basis and on a specific line-of-coverage basis, lends itself better to a qualitative rather than a quantitative assessment. Nevertheless, we will review developments in the equity position of the industry and draw conclusions about the general financial capacity to assume risks. Data limitations preclude an extension of the analysis on a specific business line basis.

To illustrate the degree of capacity in the industry we use two alternative measures: conservative and expanded. The conservative measure defines capacity (used in the charts below) as two times equity and is a measure adopted by the IAO (Insurers' Advisory Organization) that has found wide acceptance. An expanded measure of capacity providing for more efficient use of capital might be as high as 2.75 times equity. This still remains below the critical level of three times equity which the regulators use to judge a company's ability to expand its premium base.

The Canadian property-casualty insurance industry is conservatively leveraged and has had, on average, a consistent measure of excess capacity except during the "crunch period" of 1976–1977. This is illustrated in Chart 3 below, which compares capacity (defined as two times equity) and utilization in the sense of net premiums written. Capacity utilization has fallen to record lows in recent years.

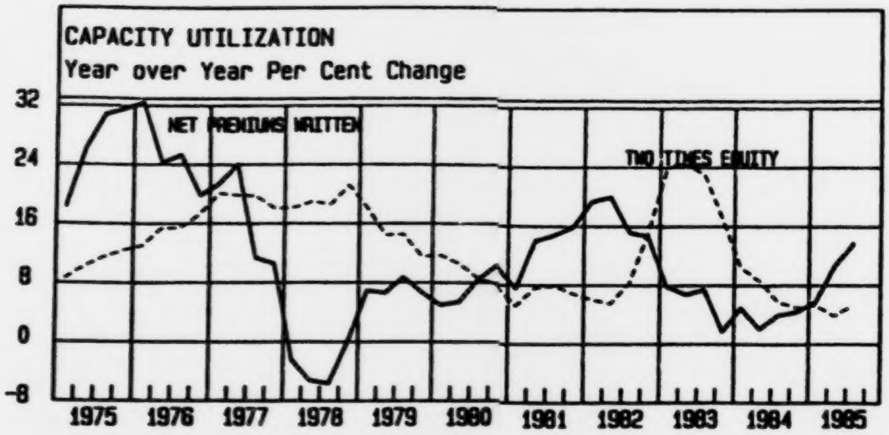
CHART 3



Source: Statistics Canada, *Financial Institutions*, Cat. No. 61-006.

Although the current excess capacity situation is rather bleak, the future outlook is buoyed by a turnaround to higher utilization rates in early 1985. As the accompanying chart illustrates, growth in premiums began to outstrip the gradually dampened expansion in capacity during 1985. However, it will require sizeable increases in premiums accompanied by static capacity to remedy the excess capacity within a reasonable time frame.

CHART 4



Source: Calculated from the data in Chart 3.

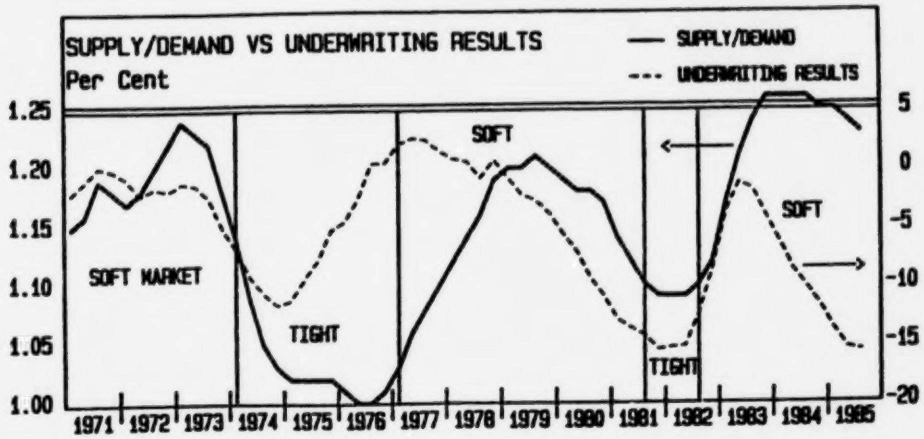
By the conservative measure, excess capacity during the third quarter of 1985 was $2.4 billion or 21.2% of capacity. This represents a measurable reduction from the peak excess level of $2.8 billion (26.8% of capacity) achieved during 1984. The patterns are identical with the expanded measure of capacity. On this basis, excess capacity during the third quarter of 1985 was $6.6 billion, or a very high 42.7% of capacity.

This analysis suggests that there is sufficient current capacity in *general* demand for insurance services for the foreseeable future. Capacity constraints or unavailability problems are obviously *localized* to particular lines of business and, therefore, require specific and focused solutions.

Implications of the Capacity Cycle

Our analysis further confirms the notion that the industry is largely supply-driven. It is the ebb and flow of excess capacity in the industry that determines the pricing cycle and ultimately, the underwriting results. Over the last decade-and-a-half, the industry has experienced two-and-a-half capacity cycles with predictable results on underwriting performance.

CHART 5



Source: Statistics Canada, *Financial Institutions*, Cat. No. 61-006 and *National Income and Expenditure Accounts*, Cat. No. 13-201; and Insurers' Advisory Organization.

Chart 5 utilizes the IAO's supply/demand monitor concept to illustrate the capacity cycle and the various episodes of soft and tight insurance markets. The supply/demand monitor is defined as equity as a share of Gross National Product and provides a graphic illustration of excess supply and excess demand periods. A surprisingly tight correlation is observed between the supply/demand condition and underwriting results (underwriting gain/loss as a percentage of earned premiums). The causal relationship that is operative in the industry is as follows:

Soft Market (Excess Capacity) ——→ Excess Competition →
——→ Low Prices ——→ Underwriting Losses ——→
——→ Tight Market (Capacity Contraction) ——→
——→ Price Increases ——→ Improved Underwriting Results ——→
——→ Soft Market (Excess Capacity) ——→

The capacity cycle would lead us to believe that the recent situation of severe underwriting losses was a result of heightened price competition brought on by excess capacity. The current capacity contractions and large price increases are predictable elements of this scenario.

The Reinsurance Cycle

The reinsurance market experiences the same wrenching adjustments on price and capacity as the primary market due to several factors:

- incomplete information on risks being underwritten by the primary insurers;
- high loss ratios due to claims growth and associated uncertainties regarding long-tail liabilities in certain lines; and
- a history of premium rate inadequacy.

TABLE 1

CANADIAN PREMIUMS IN NON-LIFE BUSINESS
(DIRECT INSURANCE AND REINSURANCE)

Year	Direct[1] Insurance	Period-to-Period % Change	Reinsurance[2]	Period-to-Period % Change	Reinsurance as a % of Direct
1979	4,970	7.0	538	26.9	10.8
1980	5,328	7.2	642	19.3	12.0
1981	6,028	13.1	818	27.4	13.6
1982	7,056	17.1	961	17.5	13.6
1983	7,456	5.7	1,098	14.3	14.7
1984	7,724	3.6	1,107	0.8	14.3

[1] Net premiums written by Property-Casualty Primary Insurers.
Source: Statistics Canada, *Financial Institutions*, Cat. No. 61-006.
[2] Gross premiums assumed by reinsurers.
Source: Canadian Insurance/Agent & Broker, Annual Statistics (1980-1985)

Several developments in Canadian direct and reinsurance markets become apparent in Table 1:

- The insurance downcycle in Canada has lagged that in world markets, particularly Western European markets. Direct insurance premium growth was strong during 1980 to 1982 and only experienced a slowdown in 1984.
- Reinsurance premiums underwent rapid growth over the period 1979 to 1983. This expansion is, in part, attributed to the aggressive marketing efforts of unregistered insurers.
- The contraction in Canadian reinsurance markets was recorded initially during 1984. This lags comparable developments in the United States market by at least a year and that in world markets by two to three years. Similarly, reinsurance premiums also lagged the slowdown in the domestic direct insurance markets.
- Reinsurance increased sharply by almost four percentage points as a share of direct insurance premiums over the period 1979 to 1983, to a peak of 14.7%. While this ratio is below the world average, it is almost twice that of the United States. This provides partial evidence of the increased reliance of domestic insurers on ceding reinsurance and reducing the retention of the business written on their own accounts. However, the increased reinsurance ratio is by no means excessive yet.

In summary, the reinsurance "crunch" did not take place in Canada until well into 1984 and 1985. This is a year to several years behind similar developments elsewhere in world markets. The withdrawing of unregistered reinsurers and "naive" reinsurers after several years of pronounced adverse experiences was a key factor. The abuse of easily available reinsurance during the good years led to inadequately low retention rates by many primary insurers. As a result, underwriting risks were disproportionately transferred to reinsurers with ultimately negative results.

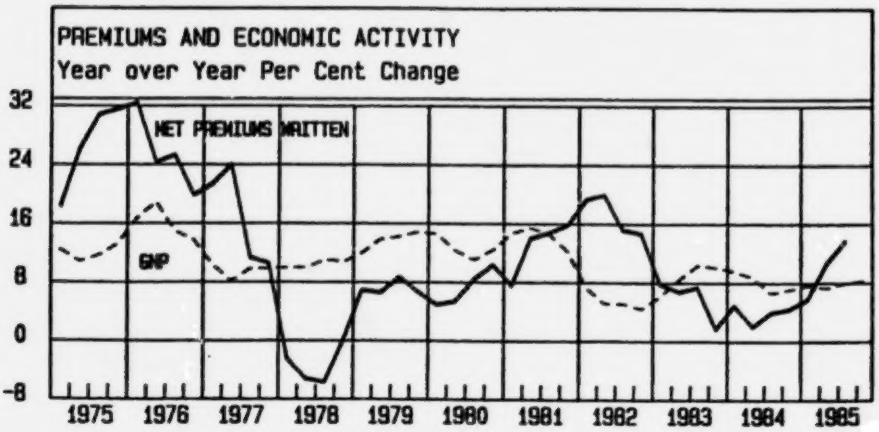
The Pricing Cycle

The conventional case is where the demand of a product is strongly related to the level of economic activity or income. The price of the product is then largely determined by excess demand conditions in the market. Property-casualty insurance services are distinctly unconventional products. The accompanying chart illustrates that the growth in premiums is surprisingly uncorrelated with changes in economic activity. Demand conditions, therefore, do not play a critical role in the market for general insurance.

The key determinant to premium growth is prices. As we have already discussed in the section on the capacity cycle, prices of general insurance services are largely supply-driven. It is the ebb and flow of excess-supply conditions in the market that determines the pricing cycle.

In summary, excess capacity and pricing are the key factors that determine the internal dynamics of the property-casualty industry in Canada.

CHART 6



Source: Statistics Canada, *Financial Institutions*, Cat. No. 61-006 and *National Income and Expenditure Accounts*, Cat. No. 13-201; and Insurers' Advisory Organization.

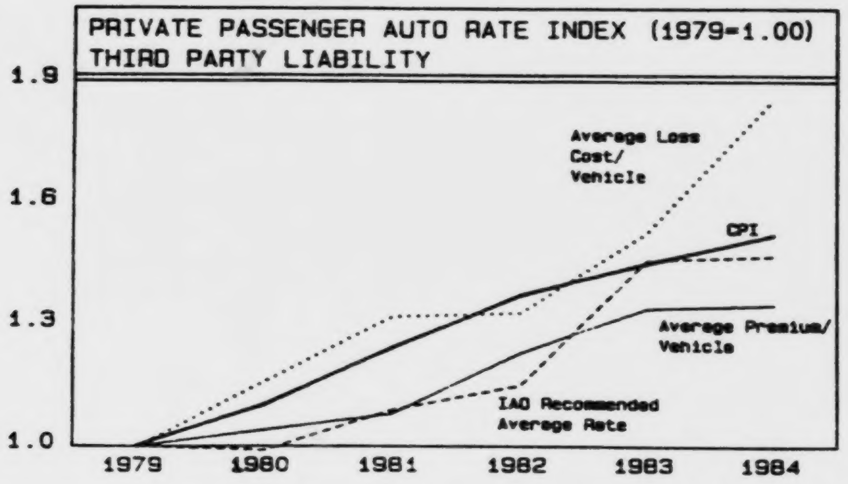
a) Private and Commercial Automobile Rates

The Insurers' Advisory Organization (IAO) has an extensive data base that summarizes rates and claims costs for various classes of coverage for private passengers and commercial automobiles. Our analysis of a representative sample of these rates portrays a picture of the premium rate inadequacy that is a key factor in the current problems.

The salient features of the experience of the private passenger automobile rates over the period 1979 to 1984 are:

- Average premiums for third-party liability lagged increases in the Consumer Price Index (CPI), the IAO recommended rate and claims losses (see Chart 7).
- In real terms, the average premium for third-party liability experienced a *cumulative decline* of 11.2% over the six years.
- Average premiums for collision and comprehensive coverage were more than adequate for losses and generally followed IAO recommended rates.

CHART 7

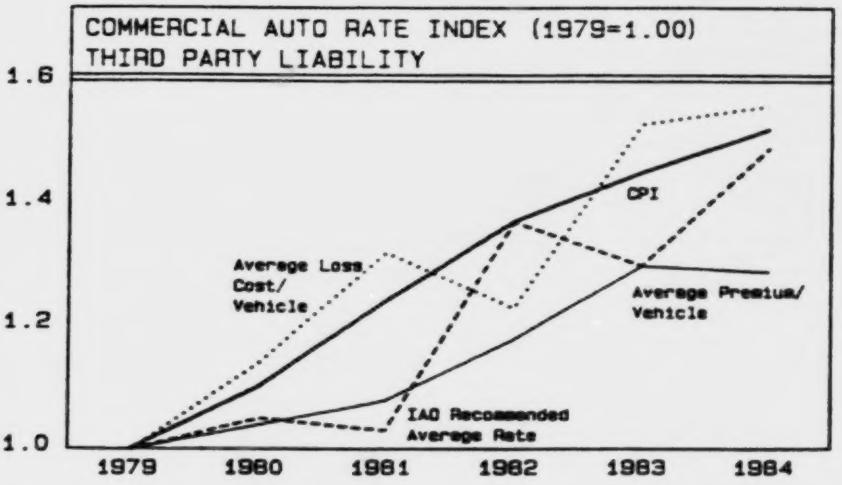


Source: Insurers' Advisory Organization of Canada and Statistics Canada. *Consumer Prices and Price Indexes*. Cat. No. 62-010.

The experience of commercial automobile rates is broadly similar to that of private passenger automobiles and is summarized below:

- Average premiums for third-party liability lagged by a wide margin increases in the CPI and IAO recommended rates and claims costs (see Chart 8).
- In real terms, the average premium for third-party liability incurred a *cumulative decline* of 15.1% over the six years.
- The premium rate experience for collision and comprehensive coverage was much more than adequate to cover losses but was below IAO recommended rates.

CHART 8



Source: Insurers' Advisory Organization of Canada and Statistics Canada. *Consumer Prices and Price Indexes*, Cat. No. 62-010.

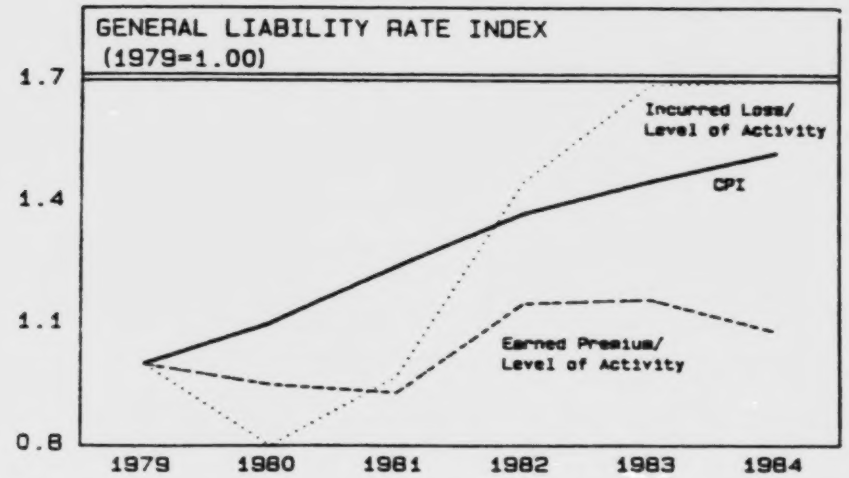
b) General Liability Rates

Liability insurance lines cover such a wide and heterogeneous variety of risks that it is difficult to summarize the general experience. In fact, the IAO contends that the statistics in the liability lines are not sufficently complete in order to provide proper direction and recommendations on risk classifications and rates. A representative general liability rate index (with all the caveats) for Canada was, however, constructed.

The experience would suggest:

- Earned premiums are significantly inadequate to cover losses and have lagged increases in the CPI by a substantial margin (see Chart 9).
- In real terms, earned premiums have experienced a *cumulative decline* of 28.9% over the six-year period reflecting the injurious competitive pricing practices.

CHART 9



Source: Insurers' Advisory Organization of Canada and Statistics Canada, *Consumer Prices and Price Indexes*, Cat. No. 62-010.

7.2 Affordability of General Insurance Services

An analysis of average family expenditures in Canada indicates that personal insurance costs are minor budgetary items (see Table 2). During 1982, personal insurance payments made to the property-casualty industry (tenants' insurance premiums, homeowners' insurance premiums, and vehicle insurance premiums) accounted for only 2.0% of the family expenditure budget. Other insurance-related expenditures include: health insurance premiums (private and public), 0.7%; life insurance premiums (including group insurance premiums), 0.8%; unemployment insurance, 0.9%; and retirement income maintenance, 2.5%.

TABLE 2

AVERAGE EXPENDITURE IN CANADA, 1978 AND 1982 ALL FAMILIES AND UNATTACHED INDIVIDUALS

	Dollars		Per Cent of Total Expenditure	
	1978	1982	1978	1982
Food	3,188.5	4,131.1	16.8	15.3
Shelter	3,060.7	4,742.0	16.1	17.5
Tenants' insurance premiums	**3.0**	**22.0**	**0.0**	**0.1**
Premiums for insurance on home	**65.4**	**146.2**	**0.3**	**0.5**
Household Operation	782.0	1,177.1	4.1	4.3
Household Furnishings and Equipment	368.4	972.0	4.6	3.6
Clothing	1,298.7	1,650.6	6.8	6.1
Personal Care	312.6	490.8	1.6	1.8
Medical and Health Care	368.1	522.2	1.9	1.9
Health insurance premiums	**142.4**	**190.0**	**0.7**	**0.7**
Tobacco and Alcoholic Beverages	613.6	892.2	3.2	3.3
Transportation	2,425.6	3,270.6	12.7	12.1
Vehicle insurance premiums	**241.8**	**382.3**	**1.3**	**1.4**
Recreation	947.7	1,261.4	5.0	4.7
Reading	108.1	157.9	0.6	0.6
Education	121.3	188.3	0.6	0.7
Miscellaneous	461.9	796.5	2.4	2.9
Total Current Consumption	**14,557.2**	**20,252.8**	**76.5**	**74.8**
Personal Taxes, Security and Gifts	4,476.6	6,809.4	23.5	25.2
Life insurance premiums including group	**175.5**	**220.0**	**0.9**	**0.8**
Annuity contracts	**27.5**	**38.1**	**0.1**	**0.1**
Unemployment insurance payments	**163.8**	**254.0**	**0.9**	**0.9**
Retirement and Pension Fund payments	**425.4**	**649.7**	**2.2**	**2.4**
TOTAL EXPENDITURE	**19,033.7**	**27,062.3**	**100.0**	**100.0**

Note: Details may not add due to rounding.
Source: Statistics Canada, *Family Expenditure in Canada*, Cat. No. 62-551 and 62-555, Occasional Percentage Calculations by the Economics Practice, The Coopers & Lybrand Consulting Group.

Although a relatively minor budgetary expenditure, sharp increases in personal insurance premiums have stretched those on tight budgets and created uncertainties in the budgeting process. A similar conclusion can be drawn for municipalities and hospitals which are faced with large premium increases. The exception in these situations is the unavailability of coverage in certain cases and the consequent resorting to reciprocal insurance arrangements.

The evidence presented in Table 3 suggests that municipal liability insurance premiums were a negligible component of the total municipal tax base in Ontario over the period 1981-1984. In fact, an estimate of municipal liability costs averaged only 0.05% of total municipal revenues in Ontario over the four-year period. Although liability insurance premiums have had some large increases during 1985 and into 1986, they are still estimated to account for only 0.1% of municipal revenues. The incidence of unanticipated large premium increases falling on smaller municipalities has caused considerable hardship.

Data from the Ontario Nurses' Association and the Canadian Medical Protective Association indicate a similar pattern of affordability and price increases to that for families and municipalities outlined above. Hospital liability insurance premiums have risen from an estimated $3.5 million in 1983-1984 (or 0.09% of the hospital operating budget) to $20.5 million during 1985-1986 (or 0.49%). Expected increases for 1986-1987 will result in premiums about $41 million or 0.95% of the total provincial hospital operating budget.

TABLE 3
MUNICIPAL LIABILITY INSURANCE COSTS AS A SHARE OF THE MUNICIPAL TAX BASE: ONTARIO
(Millions of Dollars)

	1981	1982	1983	1984
Estimate of Municipal Liability Costs (A)	6.2	5.1	5.3	6.2
Municipal Revenues (B)	10,065	11,161	12,205	13,123
A as a percentage of B	.06	.05	.04	.05

Sources: A — Frank Cowan Company Ltd., a brokerage firm insuring 70% of municipalities in Ontario. These figures were extrapolated to reflect costs of all municipalities.
B — Statistics Canada, *Provincial Economic Accounts, Experimental Data (1969-84)*, Cat. 13-213 Annual.

7.3 Financial Performance of Different Parts of the Industry

Unlike the life insurance industry, the property-casualty insurance industry has, for the most part, reported its results in accordance with generally accepted accounting principles, rendering the results comparable to other industries. This situation has existed for at least the past five years for federally incorporated insurers and federally registered Canadian branches of foreign insurers; these form the largest section of the industry. The results reported by provincially incorporated insurers might not conform with generally accepted accounting principles in some minor respects, but over the years these results should also be comparable to generally accepted results.

In addition, with the exception of federally registered Canadian branches of foreign insurers, the annual results of all Canadian insurers have been reported on by external auditors; the home offices of foreign companies generally require that the results of their Canadian branches be subjected to independent audit. Further, the loss of provisions of many of these insurers have been subjected to additional certification, often by fully qualified actuaries. Finally, examinations are routinely carried out by the examination staff of the federal and provincial Departments of Insurance for those insurers under their jurisdiction. This examination and audit process renders the property-casualty insurance industry one of the most heavily examined in Canada.

This section documents the financial performance of the property-casualty insurance industry using key industry-accepted indicators to provide a framework to examine the financial health, viability and structure of the industry. Also, an attempt has been made to compare the total Canadian and Ontario industries, although little pure Ontario data is available. This analysis focuses on the property-casualty insurance industry trends in general; such trends may not hold true for all companies and sub-groups within the industry.

Total Revenue Dollar

Based on total Canada operating results for 1984, Table 4 illustrates how a revenue dollar is expended.

TABLE 4
COMPOSITION OF TOTAL REVENUE DOLLAR: 1984
(Per Cent of Total)

	Revenue	How Revenue is Expended	
Investment Income	15	4	Profit before Income Tax
		3	Premium Taxes
Earned Premium	85	12	General Expenses
		13	Commissions
		68	Claims and Adjustment Costs
	100	100	

Source: Annual Reports of the Superintendent of Insurance, Federal and the Province of Ontario, 1984.

Review of the table indicates:

(i) The relative significance of investment income on the insurer's ability to earn profit.

(ii) The proportion of revenue paid as commission to agents on acquisition of premiums.

Return on Investment ("ROI")

Return on investment expresses net income after tax as a percentage of average shareholders' equity during a period. It is an indicator of the profitability of an insurer and is used to compare different companies or industries.

TABLE 5
COMPARATIVE RETURN ON INVESTMENTS
(Per Cent)

	Average	1984	1983	1982	1981	1980	1979
Ontario Insurers	8.8	7.6	14.9	11.1	(1.1)	7.7	12.4
Total Canadian	9.3	6.8	15.7	11.1	3.2	6.3	12.5
Banks (*1)	15.9	13.1	15.6	14.4	18.6	16.8	16.7
Trust, Savings and Loan (*1)	13.9	14.5	13.9	14.1	11.9	14.7	14.3
Utilities (*2)	12.4	13.5	11.1	9.9	12.1	13.2	14.4
Merchandising (*2)	12.2	10.6	10.9	11.2	12.5	13.6	14.3
Oil and Gas (*2)	13.0	9.7	7.5	6.8	12.9	21.7	19.6
Canadian Mid-Term Corporate Bond Yield (*3 and *4)	9.0	8.7	8.0	10.4	10.9	8.9	7.3

Source: Annual Reports of the Superintendent of Insurance, Federal and the Province of Ontario.

*1 *Source:* Annual financial statements of certain banks, trust, savings and loan companies.
*2 *Source:* Certain major companies from Financial Post Survey of Industrials.
*3 *Source:* Bank of Canada Review.
*4 Adjusted to an after-tax basis using 33-1/3% tax rate.

( ) represents a negative return.

In the absence of pure Ontario statistical information, we have defined "Ontario" companies as those which in 1984 had 55% or more of their direct written premiums in Ontario. These "Ontario" companies total 45 and account for 40% of the premiums written in the province. Of the total premiums written by these "Ontario" companies, only 25% relate to premiums written outside of Ontario.

Included in our definition of "Total Canada" are all federally registered property-casualty insurance companies, excluding the Mortgage Insurance Company of Canada. This includes Canadian, foreign and British companies. Excluded from our definition of "Total Canada" are provincial government insurers and all other provincially registered companies.

The results from the table indicate:

(i) Over the last six years Ontario insurers have realized returns that are generally comparable to, but slightly lower than, the returns earned by Canadian insurers.

(ii) With the exception of 1983, insurers in both Ontario and total Canada have been achieving a consistently lower ROI than other financial institutions such as banks and trust, savings and loan companies.

(iii) The insurance industry has encountered volatile results and has not consistently out-performed other major industrial sectors.

Early statistics for property-casualty insurers Canada-wide indicate a return on investment for 1985 of 6.9%, which is similar to the rate achieved in 1984 (Source: *The Quarterly Report*, Volume IV, Number 4, Insurers' Advisory Organization of Canada).

Underwriting Performance of Property-Casualty Insurers

(a) Loss Ratio

The loss ratio expresses claims and claims adjustment expenses as a percentage of net earned premiums.

TABLE 6
LOSS RATIO OF PROPERTY-CASUALTY INSURERS
(Per Cent)

	1984	1983	1982	1981	1980	1979	1978
Ontario Insurers	80.5	73.5	76.6	82.9	75.7	71.3	67.5
Total Canada	78.4	70.9	74.8	81.2	75.3	69.9	64.5
U.S. average (*1)	88.1	81.4	79.7	76.7	74.9	71.6	69.0
Provincial Government Insurers	93.2	93.5	96.4	97.5	106.8	95.0	86.8

*1 *Source:* 1980 to 1984: *Best's Review*, Property and Casualty Insurance Edition, January 1986 and May 1985. 1979 and 1978 SIGMA/Swiss Re 9/85 and 9/84.

Source: Annual Reports of the Superintendent of Insurance, Federal and the Province of Ontario; Annual Statements of Provincial Government Insurers.

Table 6 indicates that Ontario insurers have consistently experienced losses in excess of the Canadian average, but have performed better than United States property-casualty insurers in the years 1982 to 1984.

Results for 1985 are not yet available for Ontario insurers; however, preliminary figures for 1985 as a whole indicate that Canada has continued to experience a loss ratio deterioration to 82.5%, even though this ratio is still lower than that experienced in the United States (based on the loss ratio estimate reported by *Best's Review*, January 1986).

Direct Loss Ratio – By Line

Statistics were not available to indicate a loss ratio on a line-by-line basis. However, the direct loss ratio, which expresses direct claims and claims adjustment expenses as a percentage of direct premiums written, is indicated in Table 7 for major lines.

TABLE 7

DIRECT LOSS RATIO OF PROPERTY-CASUALTY INSURERS — BY LINE

(Per Cent)

	1984	1983	1982	1981	1980	1979	1978
Automobile							
Ontario (*1)	97	85	80	87	82	77	75
Other Provinces	72	62	67	83	82	75	71
Liability							
Ontario (*1)	90	105	85	63	48	39	67
Other Provinces	95	94	72	63	55	61	73
Property							
Ontario (*1)	63	52	65	68	64	61	51
Other Provinces	65	60	68	76	71	61	52
All Lines							
Ontario (*1)	84	75	75	78	71	68	65
Other Provinces	73	66	68	76	73	66	61

*1 Ontario statistics are as reported on INS 52 and 53 annual statements submitted to the Department of Insurance and are not our definition of "Ontario".

Source: Annual Report of the Federal Superintendent of Insurance.

The data contained in the above table indicate:

(i) The liability line is highly volatile, with marked deterioration in 1983 and 1984. This is confirmed by statistics for total Canada on an earned/incurred basis, which show loss ratios for 1983 at 100%, 1984 at 108% and 1985 at 98%. (Source: Insurers' Advisory Organization).

(ii) The automobile direct loss ratio for Ontario has significantly deteriorated since 1982.

(iii) Property insurance has a relatively stable nature.

(iv) For all lines, with the exception of 1980, the direct loss ratio for Ontario is consistently higher than for other provinces.

(b) Expense Ratio

The expense ratio expresses general expenses, commissions and premium taxes as a percentage of net premiums earned. This ratio provides an indication of a company's efficiency.

TABLE 8

EXPENSE RATIO OF PROPERTY-CASUALTY INSURERS

(Per Cent)

	1984	1983	1982	1981	1980	1979	1978
Ontario Insurers	32.0	30.2	29.6	32.9	32.3	32.2	32.7
Total Canada	34.2	33.3	33.0	34.9	35.1	34.1	33.8
U.S. average (*1)	28.9	29.1	28.7	28.0	27.0	26.0	25.8
Provincial Government Insurers							
— Automobile	14.1	13.7	14.2	13.1	16.0	17.3	16.2
— General	41.1	41.5	37.1	35.2	33.6	33.9	34.8
— Total	17.6	17.2	17.0	16.1	18.6	19.9	19.0

*1 *Source:* 1980 to 1984: *Best's Review*, Property and Casualty Insurance Edition, January 1986 and May 1985. 1979 and 1978: SIGMA/Swiss Re 9/85 and 9/84. (Calculated on a direct written basis as opposed to an earned basis).

Source: Annual Reports of the Superintendent of Insurance, Federal and the Province of Ontario; Annual Statements of Provincial Government Insurers.

Bearing in mind that expense ratios are related to the size of premiums, Table 8 indicates:

(i) Ontario insurers have consistently achieved lower expense ratios than the industry in Canada.
(ii) U.S. insurers have maintained a much lower expense ratio than total Canada or Ontario, with an expense ratio consistently below 30%.
(iii) Government insurers have the lowest expense ratios, being primarily in automobile insurance, a traditionally low-expense line of insurance.

Quarterly results for 1985 released by Statistics Canada indicate the 1985 expense ratio for total Canada at 32.8%. Statistics for Ontario insurers are not yet available. (Source: Insurers' Advisory Organization, Quarterly Report, March 26, 1986).

Expense Ratio – By Line

We were unable to extend the analysis of the expense ratio on a line-by-line basis for Ontario based on our sample of data. However, such information was available from the Insurance Bureau of Canada on a Canada-wide basis by major insurance class for a sample of 50 companies. Expenses here are expressed as a percentage of direct net written premiums as opposed to net earned premiums as is the case in our determination of the expense ratio detailed in Table 8. The expense ratio is indicated in Table 9 for major lines for 1982 to 1984; data for other years were not available.

TABLE 9
EXPENSE RATIO OF PROPERTY-CASUALTY INSURERS — BY LINE
(Per Cent)

	1984	1983	1982
Personal	37.4	37.0	36.7
Property other	41.4	41.9	41.1
Automobile	26.1	25.4	24.6
Other	37.1	37.0	37.3
All Lines Combined	32.1	31.7	31.3

Source: Insurance Bureau of Canada.

The results from the table indicate:

(i) On a line-by-line basis, expenses are a consistent percentage of the premium dollar.
(ii) Expenses for automobile insurance are less in relation to the premium dollar than expenses for other lines of insurance.

(c) Underwriting Ratio

The underwriting ratio expresses claims, general expenses, commissions and premium taxes as a percentage of net premiums earned.

TABLE 10
UNDERWRITING RATIO OF PROPERTY-CASUALTY INSURERS
(Per Cent)

	1984	1983	1982	1981	1980	1979	1978
Ontario Insurers	113	104	106	116	108	104	100
Total Canada	113	104	108	116	110	104	98
U.S. average (*1)	117	111	108	105	102	98	95
Provincial Government Insurers	111	111	113	114	125	115	106

*1 *Source:* 1980 to 1984: *Best's Review*, Property and Casualty Insurance Edition, January 1986 and May 1985. 1979 and 1978: SIGMA/Swiss Re 9/85 and 9/84.

Source: Annual Reports of the Superintendent of Insurance, Federal and the Province of Ontario; Annual Statements of Provincial Government Insurers.

The results from Table 10 indicate:

(i) Ontario's underwriting ratio is similar to those achieved in total Canada, which is due to the combinations of lower expense ratios and higher loss ratios described in the preceding sections.

(ii) The overall underwriting performance of the Canadian industry has been exceeding 100% since 1979. In other words, there has been total reliance on investment income since that time.

(iii) The United States enjoyed significantly lower underwriting ratios than both Ontario and Canada for the period from 1978 through to 1981.

(iv) The provincial government insurers' underwriting ratio has significantly exceeded the Ontario and Canadian ratios in five of the last seven years.

Quarterly results for 1985 released by Statistics Canada indicate the 1985 underwriting ratio for total Canada at 115.3%. Statistics for Ontario insurers are not available (Source: Insurers' Advisory Organization, Quarterly Report, March 26, 1986).

Investment Performance

The income that an insurer earns on its investment portfolio has a significant impact on its overall profitability. With underwriting ratios often in excess of 100%, the amount of investment income determines the amount of the insurers' profit.

TABLE 11
PRE-TAX INVESTMENT INCOME AS A PERCENTAGE OF NET PREMIUMS EARNED

	Ontario	Total Canada
1984	17.9	17.7
1983	16.1	17.3
1982	15.4	16.4
1981	15.8	18.5
1980	14.9	15.7
1979	14.9	15.0

Source: Annual Reports of the Superintendent of Insurance, Federal and the Province of Ontario.

TABLE 12
PRE-TAX INVESTMENT INCOME AS A PERCENTAGE OF AVERAGE TOTAL INVESTMENTS

	Canadian Mid-Term Pre-Tax Corporate Bond Yield	Ontario	Total Canada
1984	13.2	11.2	11.2
1983	12.0	11.0	11.7
1982	15.6	11.1	11.3
1981	16.4	10.9	12.0
1980	13.4	9.6	9.7
1979	11.0	9.4	9.1

Source: Bank of Canada Review; Annual Reports of the Superintendent of Insurance, Federal and the Province of Ontario.

Tables 11 and 12 indicate that yield ratios experienced by the industry in Ontario are generally in line with total Canadian insurers, but overall yield ratios are consistently below yields of mid-term corporate bonds.

Equity Position in the Industry

The data in Table 13 strongly support the contention that the favourable growth in equity in the property-casualty industry was mainly fueled by net income. Over the period 1975 to 1985, net income, less withdrawals, is estimated to have contributed 80% of the total growth in equity. In contrast, new share capital and contributed surplus contributed about 20% over that period.

TABLE 13
ITEMS CONTRIBUTING TO INCREASES IN TOTAL EQUITY OF PROPERTY-CASUALTY COMPANIES
(Millions of Dollars)

	Net Income	Dividends and Head Office Transfers	Others	Income Less Withdrawals	Capital and Contributed Surplus	Increases in Total Equity
1975	111	37	(109)	39	154	193
1976	277	(38)	(13)	226	76	302
1977	416	(117)	26	325	45	370
1978	443	(83)	61	421	91	512
1979	400	(68)	(17)	315	23	338
1980	212	(55)	18	175	77	252
1981	160	(79)	43	124	118	242
1982	455	(41)	34	448	121	569
1983	741	(113)	2	630	100	730
1984	362	(140)	84	306	(52)	254
1985 (9 months)	460	26	(184)	302	49	351
Cumulative Total (1975-1985)	4,037	(671)	(55)	3,311	802	4,113
Cumulative per cent Contribution	98.2	(16.3)	(1.4)	80.5	19.5	100.0

Source: Statistics Canada, *Financial Institutions*, Cat. No. 61-006.

The major disbursements out of retained earnings of companies have been dividend payments to policyholders/shareholders and transfers to head offices. The latter item encompasses the remittances of dividends, management fees, and other sundry accounts to foreign parent organizations of property-casualty companies operating in Canada. Dividends and net head office transfers detracted about 16% from the increase in total equity. Cumulative dividend payouts amounted to $641 million, and net transfers to head office over the period totalled only $30 million.

The most noteworthy feature is not the level of new capital introduced, nor perhaps the level of net income. Rather, it is the high level of retention of profits in the industry that provides the solvency and financial backing over the period.

Solvency Ratios

A key solvency ratio for property-casualty insurers is the liquidity ratio. This is the ratio of total liabilities to cash and invested assets. This provides an indication of the financial stability of an insurer by measuring its ability to meet its current financial demands. The liquidity guidelines established by the National Association of Insurance Commissioners in the United States call for the ratio not to exceed 105%.

TABLE 14
LIQUIDITY RATIO
(Per Cent)

	Ontario	**Total Canada**
1984	79	84
1983	79	82
1982	83	85
1981	84	87
1980	80	84

Source: Annual Reports of the Superintendents of Insurance, Federal and the Province of Ontario.

Both Ontario and total Canada are well within the recommended ranges, with Ontario in a slightly better position. In fact, the liquidity of both the Ontario and total Canadian insurers would appear to have improved after a slight deterioration in 1981-1982.

Other solvency ratios include the ratio of total liabilities to surplus and the ratio of net premiums written to capital and surplus. The former measures the cushion to absorb any shortfall in asset values or sudden unexpected losses. The latter indicates the degree of financial leverage used by the industry. Both these ratios indicate that Ontario is in a slightly stronger position than total Canada and that there has been a minor improvement in its liquidity position over the past five years. These results suggest that, with perhaps some minor exceptions, insurers have the financial sinews to withstand serious losses and to meet their commitments to the insuring public. Furthermore, there is additional capacity, in general, in both Ontario and the Canadian market.

Claims Reserves of Property-Casualty Insurers

Table 15 presents two ratios that indicate the significance of claims reserves for the period of 1978-1984 inclusive.

TABLE 15

MEASURES OF THE SIGNIFICANCE OF UNPAID CLAIMS RESERVES RELATIVE TO FINANCIAL OPERATIONS OF INSURERS

	*Unpaid Claims (Millions)	Per Cent of Total Capital	Per Cent of Total Assets
1984	5,822	123	39
1983	4,947	110	36
1982	4,103	110	34
1981	3,929	119	36
1980	3,632	119	36
1979	3,367	122	37
1978	3,089	126	37

*Includes all major federal registered property and casualty companies plus ten Ontario-licensed companies.
Source: Annual Reports of the Federal Superintendent of Insurance.

The conclusions derived from the above data are as follows:

- Claims reserves represent a significant portion of an insurance company's financial structure.

  Historically, for all companies combined, claims reserves have represented 35-40% of total assets and 100-120% of total capital and surplus.
- Claims reserves have experienced a sudden proportionate increase in 1984. This is the largest change for data that was readily available (i.e., 3% of total assets, 13% of total capital and surplus).
- Reserves levels in 1984 are at or close to proportionate levels maintained in 1978. For 1979-1982, reserves gradually declined in relationship to capital and surplus and total assets.

The methods of reserve determination are undergoing a radical and fundamental change. The traditional methods represented by "rules of thumb" and "experienced guessing" are gradually giving way to the more analytical and rigorous review of actuarial science.

The estimation of claims reserves adequacy by the industry is dependent on an historical consistency of individual-case reserving philosophy, claims payment rates, claims reporting rates, etc. Using an accepted reserve assessment technique, the incurred loss development method, Table 16 indicates that the claims reserves stated on the 1984 financial statements were approximately $956 million deficient (18.7% of stated reserves) on a non-discounted basis.

TABLE 16
REVIEW OF ADEQUACY OF INDUSTRY RESERVE LEVELS ALL CANADA (FEDERAL COMPANIES)/ALL LINES ESTIMATE OF ULTIMATE CLAIMS AMOUNTS ($000)

Incurred Method

Accident Year	Factor	Estimated Ultimate Cost
1980	1.00	$3,869,006
1981	1.01	4,889,616
1982	1.028	4,700,762
1983	1.047	4,647,368
1984	1.041	5,347,345
Total Estimate:		$23,454,097
Total Accounted For:		22,498,422
— Reserve Excess (Deficiency) on a non-discounted basis		(955,675)
— Excess (Deficiency) as percentage of Stated Reserves on a non-discounted basis		(18.7)

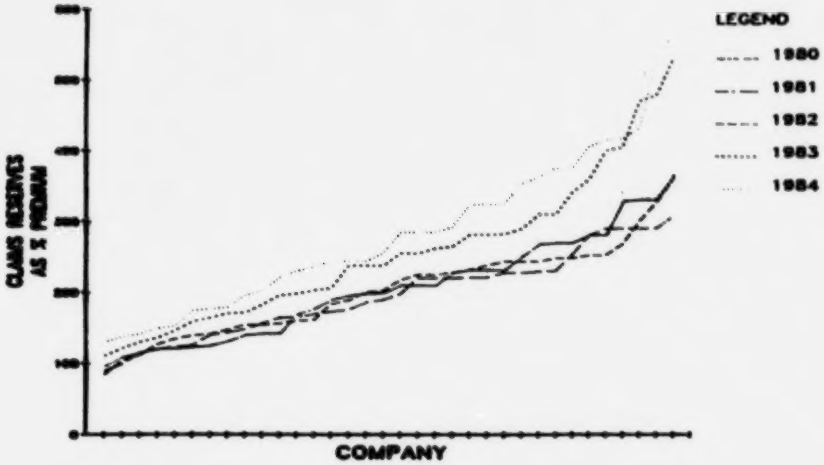
Note: Some might argue that discounting be applied to these claims reserves. However, even the application of a discount factor of 8% results in only a minor excess reserve position (1.5% of stated reserves).

Source: The Wyatt Company.

There is considerable variability among insurance companies for commercial liability reserves relative to property reserves levels. This is reflective of a wide deviation of reserving methodologies and patterns between lines of business and companies.

Commercial liability reserves showed some stability relative to premiums in 1980 and 1981, with a relative decline in 1982. Years 1983 and 1984 represented sharp upward movement in reserves proportionate to premium. This upward adjustment is reflective not only of an adjustment to a suggested premature profit taking during 1981-1982, but of the increased uncertainties regarding commercial liabilities that began to become evident during that period (see Chart 10).

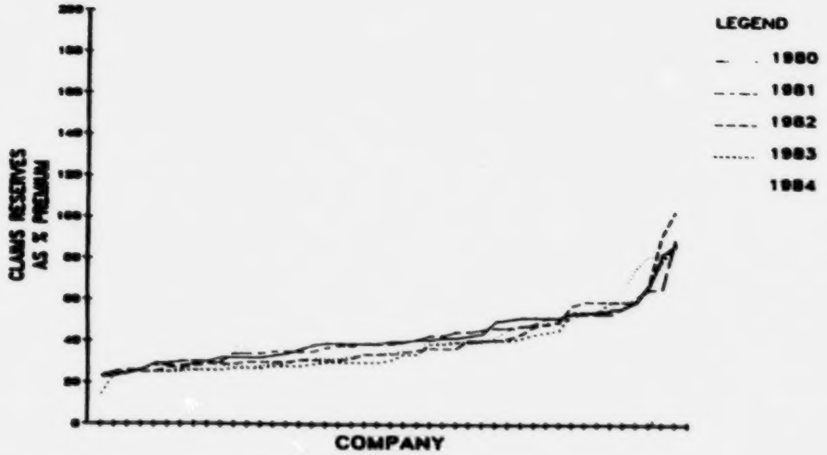
CHART 10
COMMERCIAL LIABILITY RESERVE VARIABILITY AMONG 34 CANADIAN COMPANIES



Source: 1985 Insurance TRAC Report.

Property reserves relative to premiums show a great deal more stability both among companies and from year to year than does liability (see Chart 11). Property reserves have, in the main, been keeping the same relative position to premiums over the years 1980-1984.

CHART 11
PROPERTY RESERVE VARIABILITY AMONG 34 CANADIAN COMPANIES



Source: 1985 Insurance TRAC Report.

Recent Failures of Property-Casualty Insurers

Until 1980, Canada had experienced only a few failures in the property-casualty insurance industry in fifty years. The 1980s, however, have seen a spate of insurance company failures, such as:

Cardinal Insurance Company;
Northumberland General Insurance Company;
The Pitts Insurance Company; and
Strathcona Insurance Company.

In addition, at least two other entities failed for reasons other than local insolvency. These entities were the United Canada Insurance Company, and the Canadian branch of Ideal Mutual Insurance Company. In both instances, the main company, or parent company in the United States, failed and, largely as a result, the Canadian operations had to be liquidated. To our knowledge, both were solvent at the time that they were liquidated.

Furthermore, there have also been at least thirteen recent voluntary wind-ups of insurance companies in which insolvency was not the major cause. In most cases, insurance companies or branches were dissolved for reasons such as merger with another insurance company or domestication of a Canadian branch into a related Canadian insurance company.

In summary, we believe that it is fair to say that the most prevalent cause for insurance company failure is the relationship of an insurer with related companies, either by way of management agency contracts or reinsurance, resulting in liquidity problems. Fortunately, the total business of the failed insurance companies has been insignificant to the total industry.

Reinsurance Companies

In contrast to the long history of primary insurers based in Canada, the first specialized reinsurance companies in the country were only established in the post-1945 era.

TABLE 17
REINSURANCE COMPANIES IN CANADA
(1979 - 1984)

		Net Premiums Written					
Year	**Number of Companies**	**($000)**	**Per Cent Change**	**Gross Premiums Assumed ($000)**	**Underwriting Profit/Loss ($000)**	**Investment Income ($000)**	**Operating Profit ($000)**
1979	23	369,798	4.0	538,257	− 20,585	67,130	46,545
1980	30	447,275	21.0	641,992	− 57,808	85,823	28,015
1981	39	565,681	26.5	817,992	− 110,906	113,378	2,472
1982	42	669,769	18.4	961,456	− 85,278	150,743	65,465
1983	46	654,145	− 2.3	1,098,419	− 85,593	166,161	80,568
1984	47	684,585	4.7	1,107,264	− 93,905	183,633	89,728
Cumulative six-year totals					− 454,075	766,868	312,793

Source: Canadian Insurance/Agent and Broker, Annual Statistics (1980-1985).

In the recent past, the number of reinsurance companies doubled from 23 in 1979 to 47 during 1984. For the latest year, reinsurance companies assumed gross premiums of $1.1 billion and wrote net premiums that amounted to $685 million.

An easy market in reinsurance was much in evidence during 1980 to 1982 as net premiums averaged an annual growth of about 22%. Reflecting the lagged effects of the contraction of world reinsurance markets, there was a sharp correction in net premiums written during 1983; these have since remained relatively flat.

Similar to, and indeed a reflection of, the underwriting experience of primary insurers, reinsurance companies suffered consistent underwriting losses. Over the six-year period 1979 to 1984, the cumulative underwriting loss totalled $454 million, only to be offset by $767 million in investment income.

The aggregate results suggest that the Canadian reinsurance industry is solvent and profitable. However, certain *deviations* from this norm may occur in *specific business lines* within individual companies.

7.4 Proximate Explanation of Cycles of Availability, Price and Profitability

The Claims Experience

The property-casualty insurance industry has had an adverse experience with claims over the last decade. In the recent past, 1980-1984, claims growth for all lines of business averaged 10.0% per year, whereas net premiums earned increased only 9.5%. The trends, however, have been distinctly unfavourable as claims growth exceeded that of premiums by a multiple of roughly three times during 1984.

Key factors that determine the claims experience of property-casualty insurers are:

- the number and size of court awards;
- the number of claims paid out-of-court;
- the average value of claims paid; and
- the frequency of claims incurred.

Recently, court awards, although small in relation to total claims, have biased upwards the majority of out-of-court settlements. Judicial developments such as the reform of the *Family Law Act* and the "Spills Bill" have only recently had an impact on the settlements experience but they are expected to have a major impact in the future.

Table 18 provides an overview of the claims experience over the period 1980-1984 for selected classes. The crisis in claims associated with liability insurance is clearly evidenced by the fact that the average growth in such claims exceeded the average for all classes by a wide margin. High claims growth for mortgage insurance can be readily explained by the unprecedented rise in interest rates and the severe recessionary experience of the early 1980s.

TABLE 18
CLAIMS EXPERIENCE BY SELECTED CLASS
(1980-1984)

Class	**Cumulative (Net) Losses Incurred ($ Millions)**	**Average Annual Growth in Claims (Per Cent)**	**Average Loss Ratio (Per Cent)**
Automobile	12,936	10.6	81.5
Property	8,137	6.1	67.1
Liability	2,017	24.4	85.1
Mortgage	415	27.1	238.5
Wet Marine	200	4.5	74.5
Aircraft	190	0.9	78.1
Boiler	138	16.1	44.2
Guarantee (Surety)	120	15.3	34.7
All Classes Combined	34,048	10.0	79.3

Source: Canadian Underwriter, 52nd May Statistical Issue, May 1985.

The availability of good claims/loss cost statistics for automobile coverage facilitates the identification of the key determinants of the recent experience in the largest business line. Several conclusions can be drawn from the evidence presented in Tables 19 and 20:

- Large claims do not appear to be, in themselves, a reason for rapid increases in overall claims. Their effect on influencing the standards for out-of-court settlements is much more substantial.
- The frequency of claims declined over the period 1981-1983 and has subsequently edged upwards. When viewed over the entire period 1981-1985, frequency of claims is not a contributing factor to claims growth; however, the recent upturn during 1984 and 1985 has definitely contributed to overall claims growth.
- The average cost per claim has risen substantially and is the critical factor underlying overall automobile claims growth.

- Not only is the average cost per claim in Ontario roughly 1.75 times the level of that in Alberta and the Atlantic provinces, but the rate of growth is also two or three times that of the other provinces.
- The frequency of claims in Ontario was roughly the average experience in Canada during 1981-1983 and exceeded the average Canadian experience during 1984-1985. It has tended to be higher than that of the Atlantic provinces throughout and lower than the Alberta experience during 1981-1982 while higher during 1983-1985.

TABLE 19
LOSS EXPERIENCE FOR CLAIMS EXCEEDING $50,000

	Policy Year	Estimated Ultimate Number of Claims	Estimated Ultimate Total Value of Claims ($ Thousands)
Private Passenger			
	1981	1,167	$189,182
	1982	1,270	205,162
	1983	1,381	235,878
	1984	1,325	235,055
	1985*	1,042	240,737
Commercial			
	1981	142	28,525
	1982	117	22,137
	1983	125	24,040
	1984	117	18,071
	1985*	105	24,949

*Preliminary estimate for policy year 1985, subject to substantial upward revisions.

Note: These figures were calculated on the assumption that the ultimate period of claims development is 42 months.

Source: Green Book: The Automobile Experience, Insurance Bureau of Canada, 1985.

TABLE 20
TREND OR LOSS COST EXHIBITS, THIRD-PARTY LIABILITY PRIVATE PASSENGER AUTOMOBILES — EXCLUDING FARMERS BODILY INJURY AND PROPERTY DAMAGE LIABILITY COMBINED

Province	Policy Year[a]	Number of Cars Insured (1)	Claim Frequency per 100 Cars Insured (2)	Average Cost per Claim (3)	Loss Cost per Car Insured (4)
ALBERTA	1980	967,498	6.97	1,958	136.50
	1981	1,040,571	6.94	2,205	153.00
	1982	1,085,644	6.34	2,207	139.87
	1983	1,096,235	5.34	2,531	135.12
	1984	1,123,885	5.20	2,520	131.08
ATLANTIC PROVINCES	1980	748,385	6.05	1,810	109.46
	1981	763,048	6.15	1,958	120.47
	1982	773,399	5.62	2,036	114.48
	1983	787,105	5.17	2,435	125.95
	1984	819,179	5.39	2,400	129.30
ONTARIO	1980	3,420,996	6.80	2,336	158.83
	1981	3,475,637	6.69	2,701	180.68
	1982	3,513,521	5.96	3,063	182.48
	1983	3,597,887	5.46	3,828	209.06
	1984	3,782,117	5.89	4,330	255.01
COUNTRYWIDE EXCLUDING QUEBEC	1980	5,136,879	6.72	2,193	147.43
	1981	5,279,256	6.66	2,500	166.52
	1982	5,372,564	5.99	2,741	164.08
	1983	5,481,227	5.40	3,379	182.34
	1984	5,725,181	5.68	3,743	212.70

[a] Policy years cover a fiscal-policy-year statistical period; for example, "1985" consists of policies effected in the 12 months from July 1, 1984 through June 30, 1985.

Source: Green Book: The Automobile Experience, Insurance Bureau of Canada, 1985.

Expense Developments

Expenses that property-casualty insurers experience which are not related to claims and adjustments are: operating expenses, taxes, licences and fees, and commissions. In section 7.3 we reviewed the expense ratio, which expresses such expenses as a percentage of net premiums earned. Over the period 1978-1984, the expense ratio for total Canada averaged 34.1%. The experience during 1984 varied considerably by business line: from a low of 26.1% for automobile coverage, the expense ratio extended to a high of 41.4% for commercial property (see Table 9).

The fairly stable relationship observed between general expenses and net earned premiums over the period 1978-1984 suggests a fairly stagnant productivity situation. That is, the level of input (expenses) for a given level of output (earned premiums) has remained stable. This situation is readily explained by the structure of the property-casualty market and the resulting lack of economies of scale.

Commissions

During 1984, commissions were 14% of total net premiums earned. At first glance, this level appears to be rather high and indicates an inefficient system of distribution of risk protection products to the public. Furthermore, the high and stable commission rate also signifies a constraint in the ability of the marketplace to deliver cost-efficient services to the public by narrowing margins. It is, however, argued that existing commission rates are by no means excessive, as they essentially cover costs of the substantial follow-up service activity that is involved in providing property-casualty insurance products, particularly for automobile coverage.

TABLE 21
COMMISSION RATES BY LINE OF BUSINESS: 1984
(Per Cent)

Automobile	11.8
Commercial Property	19.8
Personal Lines Property	20.3
General Liability	18.8
All Lines Combined	13.0

Source: Insurance Bureau of Canada.

The wide discrepancy in commission rates by line of business is, however, reflective of the degree of competition in that segment of the market. Commission rates are lowest for automobile policies, where the market is the most competitive. Enhanced competition among existing and alternate distribution channels would, therefore, benefit the policyholder measurably.

Reinsurance Costs

Two major developments in reinsurance markets in the 1980s have shaped the current situation. First, the easy market in reinsurance that prevailed in the early 1980s saw reinsurance costs fall in the face of new capacity from unregistered and non-traditional reinsurers. There was evidence of abuse of this new capacity, particularly in liability lines where a disproportionate share of risks was transferred to the reinsurer with ultimately negative results. Second, the underwriting experiences of reinsurers deteriorated considerably with a consequent general withdrawal of capacity and a total withdrawal in certain liability lines. In fact, the coverage offered by non-traditional reinsurers has all but disappeared. The sum total of these developments has been a marked rise in reinsurance costs in most lines and substantial increases in certain lines where residual reinsurance is still offered.

These developments are clearly illustrated for Ontario insurers in the diverging trends in Table 22. While the percentage of direct premiums written ceded to reinsurers has declined since 1980, the reinsurers' share of the claims expenses has grown disproportionately. These market experiences, along with preliminary indications that Ontario is converging to the litigious environment of the United States, have not gone unnoticed by international reinsurers.

TABLE 22
ONTARIO INSURERS' REINSURANCE AS A PERCENTAGE OF

	Direct Premiums Written	Direct Claims and Adjustment Expenses
1984	33	41
1983	31	37
1982	32	32
1981	36	33
1980	38	29

Source: TRAC 1985, The Wyatt Company.

The perceptions held by Lloyd's about continuing business relationships with North America and Ontario are noteworthy and are representative of international reinsurers. Such perceptions are also a harbinger of cost and availability conditions well into the future. These largely unfavourable views can be summarized as follows:

- Generally, the Canadian insurance market is not distinguished from that in the United States.
- It is generally considered that premium rates will continue to escalate.
- There appears to be little further capacity in the London market for liability risks, particularly emanating from North America.
- Lloyd's has been withdrawing over the past ten years from the North American liability insurance market, with only a few risks remaining.
- It is generally considered that Lloyd's will not return to the North American liability insurance market for many years, if ever.

Industrial Structures and Dynamics of Adjustment

The Canadian property-casualty insurance industry can be easily and accurately described by the competitive market model. The characteristics of such a market model are:

- It is highly fragmented, with no one company or small group of companies having any significant market power;
- It lacks any economies of scale; and
- It is devoid of any significant barriers to entry for either domestic or foreign companies.

This competitive characterization of the industry puts into perspective the behaviour and performance that we currently observe. As we would anticipate, the lack of barriers to entry and aggressive pricing behaviour by the industry have led to the build-up of excess capacity for most product lines. The extreme competitiveness in the industry also ensured that aggressive pricing continued despite protracted losses on underwriting until capacity constraints emerged or solvency conditions became critical. The predominant distribution channel of the industry, general agents/brokers, was also a key factor in allowing premium rate inadequacy to persist due to the discretion they possessed in directing business to the low-cost producer.

Shocks to the Property-Casualty Insurance Market

The recent cyclical downturn in the property-casualty industry was exaggerated by a set of conflicting factors, internal and external to the industry. These factors impeded the inherent self-corrective mechanisms in the industry that usually work towards alleviating cyclical problems. Unfortunately, events have combined to create structural problems in the market which are critical and which require specific and focused policy solutions. In this section we will review the series of shocks that the property-casualty market was subjected to over the recent past.

(a) **Value of Claims**

As discussed earlier, the increasing value of claims rather than their frequency was primarily responsible for rising automobile claims. Various other environmental disasters and the accumulating experience of long-tail liabilities have aggravated recent claims costs.

(b) **Reserves**

The general deficiency of claims reserves, discussed in section 7.3, is a growing concern for the industry. This inadequacy was a result of the widely divergent reserving techniques utilized, underestimated claims payments, and probable premature profit-taking. As reserves inadequacy was particularly acute in liability lines, it has undoubtedly contributed to the "capacity crunch" in those lines.

(c) **Interest Rates**

The relatively high interest rates since the late 1970s have buoyed the investment income picture of property-casualty insurance companies. This development has helped offset growing underwriting losses and kept most companies solvent. It is also conjectured that high investment earnings, acting as a wide safety buffer, have contributed to the injurious competitive pricing and underwriting practices by the industry. In other words, this safety buffer allowed the emphasis behind premium setting to shift from covering actual liabilities to gaining market share in premiums. Indeed, the expectations of increased investment income had a profound impact on the management psychology that allowed consistent annual real declines in premium rates of 2.0% to 2.5%.

(d) **Reinsurance Prices**

The "reinsurance crunch" that became evident in Canada in 1984-1985, two to three years after the similar experience in international and United States markets, led to marked increases in reinsurance costs. These price increases, combined with a withdrawal of available capacity, have had their most pronounced impact on liability lines.

(e) **General Economic Conditions**

The steepest business cycle downturn in Canada since the 1930s occurred during 1981-1982. A combination of worse inflationary and productivity experiences than our major trading partners helped accentuate the downturn. Employment losses in 1982 were dramatic and an indicator of the economy correcting the productivity malaise through dislocations in inefficient sectors. The severe dislocations, caused as significant segments of the labour force were forced to participate in the industrial re-adjustments, contributed in a measurable way to the massive rise in liability claims. Another key contributing factor arose from the frictions associated with the adjustments that businesses themselves underwent as the financially weak and inefficient were weeded out. As most of this turbulent adjustment period is behind us, the outlook is for a relatively stable period and, consequently, these factors will play a lesser role in future liability claims.

Perhaps the most serious and lingering effect of the excess inflation period of the 1970s is on the settlements and pre-judgment interest awarded in liability claims. While the powerful and pervasive effects of the disinflationary trend have taken hold in most markets, they have not done so in the administrative system of civil justice. A closer examination of recent awards of high claims reveals an implicit expectation of future inflation rates in the 8% to 9% range. This can seriously bias settlement costs upwards when realistic expectations of long-term inflation continue to be in the 4% to 5% range.

(f) **Exchange Rates**

The Canadian dollar has experienced a major depreciation against the strong currencies of the world over the last decade. At current levels, the Canadian dollar has experienced a cumulative depreciation of about 30% relative to the United States dollar and roughly 52% against the Japanese yen.

It can be reasonably argued that our depreciating currency has had some direct implications for the property-casualty industry, most notably on claims costs. The lower dollar has resulted in higher import costs for automobiles and automobile parts. This trend has been particularly pronounced due to the sharp deterioration against the Japanese yen and the rising market share of Japanese imports. The lower dollar has not had its effects limited to offshore import costs; North American automobile costs have also reflected the deterioration against the United States dollar. The sum total of these experiences is that claims costs associated with automobile coverage have been exacerbated by currency fluctuations.

(g) **Changes in Laws and Regulations**

The reform of the *Family Law Act* in Ontario has clarified a whole new set of rights and claims which will undoubtedly affect the frequency and value of settlements. In addition, the recent enactment of the environmentally related "Spills Bill" has created tremendous uncertainties for insurers attempting to quantify the expected liability fall-out. While desirable from a social standpoint, these changes in laws were poorly timed from the property-casualty industry's position of already addressing a severe underwriting downcycle. These changes should bias premium rates upwards.

Federal and provincial regulators have already raised capitalization requirements for property-casualty insurers in response to recent insolvencies. Various regulatory changes that govern the use of reinsurance and limit the operations of the unregistered reinsurer are under consideration. The effect of all these changes is to engender a financially stronger industry but limit the introduction of new capacity.

APPENDIX 8

AN OVERVIEW OF METHODS AND ESTIMATES OF CLAIM RESERVE LIABILITIES FOR THE PROPERTY/CASUALTY INSURANCE INDUSTRY

April 10, 1986

W. R. Andrus
The Wyatt Company

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AN OVERVIEW OF METHODS AND ESTIMATES OF CLAIM RESERVE LIABILITIES FOR THE PROPERTY/CASUALTY INSURANCE INDUSTRY

A/ SUMMARY

The conclusions derived and supported herein are as follows:

- Claims reserves represent a significant portion of an insurance company's financial structure.
- Historically, for all companies combined, claims reserves have represented 35%-40% of total assets and 110%-120% of total capital and surplus.
- Claims reserves have experienced a sudden proportionate increase in 1984. This is the largest annual change for data that was readily available (i.e., increases of 3% of total assets, 13% of total capital and surplus over 1983 levels).
- Reserve levels in 1984 are at or close to proportionate levels maintained in 1978. For the years 1979-1982, reserves gradually declined in relationship to capital and surplus and total assets.
- Accurate quantification of reserves is a difficult and complex science. This difficulty is further exacerbated by the various vested interests having influence on the final reserve determination.
- The methods of reserve determination are undergoing a radical and fundamental change. The traditional methods represented by "rules of thumb" and "experienced guessing" are gradually giving way to the more analytical and vigorous review of actuarial science.

  This change has been fueled by both economic and judicial inflation and more recently by regulators and insurance industry leaders.
- The actuarial methods are constrained to some degree by the characteristics of certain lines of business combined with poor insurance company internal management information systems. These constraints will be overcome in the foreseeable future, assisted in part by regulators demanding actuarial reserve certification and insurers themselves moving to state-of-the-art information systems.
- Using two generally accepted reserve assessment techniques it can be shown that the claims reserves stated on the 1984 financial statements were approximately $956 million deficient (18.7% of stated reserves) on a non-discounted basis.
- It is shown that reserve methods vary greatly among insurance companies for commercial liability business. The minimum/maximum range is consistently in the range of 1-3 times.
- Commercial liability reserves showed some stability relative to premiums in 1980 and 1981 with a relative decline in 1982. Years 1983 and 1984 represented sharp upward movement in reserves proportionate to premium. (Refer to Appendix II.)
- Property reserves relative to premiums show a great deal more stability both among companies and from year to year than does liability. Property reserves have, in the main, been keeping the same relative position to premiums over the years 1980-1984. (Refer to Appendix II.)
- There is an equity on the balance sheets of insurers that is not accounted for. This equity is the difference between the stated reserves and the present value of the ultimate disposition of the claims. The value of this equity is dependent on:
  - i) adequacy of stated reserves;
  - ii) interest rate assumptions; and
  - iii) assumed future payout stream of claim liabilities.

Calculations are presented in this report to show that this equity at the end of 1984 had a value of $77-464 million. This range represents interest rate assumptions of 8%-12% respectively. (Refer to Appendix IV.)

The most accurate interest rate to use at a given point in time is that which results from scheduling fixed income maturities to match the assumed payout rate, thereby immunizing against reinvestment risk.

This paper assumes that at December 31, 1984, this rate of interest was in the range of 8%-12%.

B/ INTRODUCTION

The purpose of this report is to present comments on the adequacy of claims reserves of various parts of the industry.

This paper will highlight the relevant concepts underlying the reserve determination process and present various measures of adequacy.

It also provides an overview of the forces creating the cyclical nature of over- and under-provision of reserves.

C/ RESERVES — SIGNIFICANCE ON AN INSURER'S FINANCES

Table 1 below presents two ratios that indicate the significance of claims reserves for the period 1978-1984 inclusive.

TABLE 1

MEASURES OF THE SIGNIFICANCE OF UNPAID CLAIMS RESERVES RELATIVE TO FINANCIAL OPERATIONS OF INSURERS

Year	*Unpaid Claims (millions)	% of Total Capital	% of Total Assets
1984	5,822	123	39
1983	4,947	110	36
1982	4,103	110	34
1981	3,929	119	36
1980	3,632	119	36
1979	3,367	122	37
1978	3,089	126	37

*Includes all major federally registered property and casualty companies plus 10 Ontario-licensed companies.

These data indicate that:

(i) Claims reserves are a major element of an insurance company's finances.

This item alone accounts for over 1/3 of total assets and over 110% of total capital.

(ii) The reserve levels at the end of 1984, while experiencing a sudden upward movement from 1983 levels, were only at or close to the proportionate levels of 1978.

(iii) The period 1980-1983 shows a progressive relative decline in reserve levels. It can be argued that the reserve corrections experienced in 1984 and possibly in 1985 (data as yet unavailable) were due to premature profit-taking in the 1980-1983 period.

D/ RESERVES — OPPOSING FORCES

The determination of adequate claims reserve liabilities has numerous opposing forces. These forces and their effects are discussed below.

Insurance Regulatory Authorities

The primary interest of these bodies is protection of the public by assurances that the company has sufficient monies to pay all claim liabilities. Therefore, the thrust is to ensure a conservative level of reserve-setting. The regulatory authorities perform periodic reviews of a company's historical record of reserving accuracy and make their views known to senior management. In cases where warranted, the regulator has encouraged the company to obtain the opinion of an independent casualty actuary. The regulators, both federal and provincial, are taking much stronger steps in this regard in that legislation requiring actuarial certification of the loss reserves has been drafted and is expected to be enacted within one to two years from the date of writing.

Taxation Authorities

Insurance companies are allowed to establish *pre-tax* claims reserves as a cost of doing business. The tax department is a strong influence on insurers to minimize reserves for fear of incurring penalties (fines) and the embarrassment associated with corporate tax reviews.

Several Ontario-based Canadian insurers have recently been under investigation from taxation authorities. All cases have resulted in considerable expense to the insurers yet most have been concluded in favour of the insurer.

After this latest round of challenges from the tax authorities, insurers appear to have obtained a reasonably firm tax ruling confirming that reserves for losses that have occurred, but are not yet reported, qualify as a pre-tax expense, yet this is still open to challenge if the tax authorities feel the system is being abused.

Catastrophe reserves have not attained this pre-tax qualification. The author is not aware of any rulings, pro or con, by the tax authorities on the issue of catastrophe reserves but research of the insurance company's management has confirmed that there is virtually unanimous opinion indicating an unfavourable tax consequence should a company try to achieve such a deduction.

The Task Force chose a catastrophe situation (hail storm) as a specific case study. This case was that of Ontario greenhouses centrally located in the Tillsonburg area. These greenhouses are exposed to potential total devastation by climatic events due to their extreme geographic concentration, and there was such a storm in May 1985 causing approximately $11 million in insured damages. The insurers therefore suffered an extremely severe underwriting loss in 1985 and, notwithstanding profits realized in prior years, were extremely reluctant to continue providing insurance to these properties.

The pricing of the catastrophic insurance product is dependent on assuming a certain frequency of severe climatic occurrences. Valid arguments can be made that the companies should be allowed to expense the claims experience on the same assumptions used in setting the premium. A favourable ruling by the tax department in this regard would substantially contribute to the removal of the supply/profit instability of natural catastrophe insurance.

Shareholders

Shareholders' primary interest lies in maximizing the rate of return on their investment. Therefore their influence tends to a minimization of reserve levels.

To the extent that company management are shareholders or are remunerated directly in proportion to shareholders' gains, this reserve minimization can often lead to understatement.

Management, by lowering reserves, convinces shareholders that the business is generating profits. Shareholders then respond by encouraging management to write more premiums under the expectation of increasing profit. Management responds by reducing premium levels to attract competitors' business which, of course, only makes it more difficult to immediately recognize the reserve shortfall.

This process, commonly referred to in the industry as "cash flow" underwriting, only contributes to making the underwriting cycle more volatile.

It is widely perceived that the 1985–1986 market shortage/price increases are the effect of such practices carried on in 1980–1982 culminating in a sudden realization of reserve shortfall in 1984 and 1985.

The graphs shown in Appendix II referring to Liability Reserve Variability confirm this activity.

Brokers (Intermediaries)

Insurance intermediaries are contractually remunerated by a flat "up-front" commission and a "profit" commission on the business forwarded to the insurer.

Since the reserves directly affect profit, the brokers exert an influence to minimize reserves and thereby exaggerate profit and their remuneration. The insurer is often forced to recognize this or face losing considerable business to a competitor with less conservative reserving standards.

Brokers exert an influence in that they tend to move insureds to the lowest-priced insurers. Invariably the lower-priced insurers are identified in the long term as companies with more liberal reserving standards.

E/ DETERMINATION OF RESERVES

Traditional Methods

The determination of adequate reserves is a problem as old as the insurance business itself. Insurers have traditionally faced the challenge in a rather simplified non-vigorous manner. The traditional methods include assessing case reserves on individual merit plus a "rule of thumb" for IBNR reserves.

The "rules of thumb" included:

(i) one or two months' premium(s);
(ii) a fixed percentage of total case reserves; and
(iii) a fixed percentage of premiums written, which varies by line of business.

The reserve levels so determined were reasonably stable from one year to the next and as such did not command extraordinary attention. Consequently the insurance industry did little to enhance its ability to follow claims development by designing superior state-of-the-art data bases or by incorporating a sophisticated level of statistical/actuarial analysis into its reserve-setting process.

The shortcomings of traditional methods became apparent during the period of high inflation (economic and judiciary) extending from the middle of the 1970s to the present day, yet many insurers (especially smaller ones) have delayed recognition of this situation until 1984–1985, citing either competitive market forces or sudden and dramatic court decisions as the main reason for inaction.

Actuarial Methods

General Background

Most of the larger insurers have turned to acquiring actuarial expertise to assist in determining levels of claims reserves. Today virtually all of the top 25 insurers in Canada have this discipline on staff.

The actuarial profession is specifically trained in the science of determining adequate levels of claims reserves.

The Canadian Institute of Actuaries recently published a set of recommendations for determining property/casualty insurance company reserves.

It is the intent of the Institute to review the recommendations after a one-year trial period and make improvements where indicated.

A copy of these recommendations is attached as Appendix I.

While it is beyond the scope of this paper to present the technical detail used by actuaries, they generally examine historical emergence patterns of claim development. This body of data is adjusted for all significant changes to allow a simulation of historical development given current conditions (i.e., judicial awards, pre-judgment interest, inflation, etc.). This adjusted data is then used as an approximator of ultimate claim disposition from which indicated reserve levels are calculated.

It is basic to the actuarial process that numerous methods be used to develop a range of likely outcomes and attempt to identify any underlying convergence of indications.

Credibility

Smaller insurance companies are often exposed to very wide ranges of possible outcomes when measured strictly on their own historical record. Actuaries refer to this difficulty as a lack of statistical credibility and seek to overcome this by referring to larger bodies of similar data. This can often take the form of industry-wide experience but is often limited by the availability of appropriate industry data.

This data shortcoming is referred to later in this report.

Applicability to Lines of Business

The methods used by actuaries are ideally suited for those lines of business where:

(i) individual exposure units are relatively homogeneous;
(ii) there is a reasonably high degree of claim activity; and
(iii) claim data is available in various known layers. In other words, the data should be adjusted for infrequent "shock claims".

Automobile and property insurance are ideal applicants for actuarial methods. Since these two lines of business account for the majority of insurance premiums in Canada, the industry's actuaries have focused their energies into this area.

Commercial liability does not have the statistical credibility or homogeneity of the two major insurance lines and consequently the insurers have widely ranging approaches to setting these reserves.

F/ DATA CONSTRAINTS

A data base sufficient to review and assess claim reserve adequacy should have at least the following detail available:

(i) Accident year/development year;
(ii) Line of business (at minimal detail level of regulatory financial statement or finer);
(iii) Claims expenditures divided by

- amounts paid — closed and open claims;
- allocated adjustment expenses — paid;
- outstanding reserves allocated by claim file;

The claim expenses identified above should be available before and after accounting for the effect of reinsurance;

(iv) Claim counts provided in same detail as item (iii);
(v) Exposure data by accident year (e.g., car-year, house-year, # lawyers — professional liability, # beds — hospital insurance, etc.);
(vi) Premium data by accident year.

Only the larger and more technologically sophisticated insurers have an internal data base meeting these minimal requirements.

There has, in the past, been an absence of "recognized need" for insurers to invest the necessary resources to enhance the internal management information systems.

The pressure for more refined data comes usually from two sources: regulatory, and industry association.

The regulators prescribe a standard financial statement to be completed by all licensed insurers within the domain of the regulatory body.

Both federal and provincial regulatory statements require historical claim development experience but at an extremely low level of detail. A copy of such an exhibit is attached as Appendix V.

The major shortcoming of this exhibit is that it combines all lines of business into one exhibit. Consequently the analytical value of this exhibit is very limited for all but the largest of companies.

Industry associations have produced and maintain detailed statistical plans. The detail available in these plans exceeds the requirements presented above.

Unfortunately the associations have not shown an interest in providing the individual insurer members with claim development detail reports. Reasons given for this inaction include competitive pressures between association members, extra expense to the association, inaccurate data, etc.

It is reasonable to expect that if actuarial certification of reserves is required this will apply significant pressure to both insurers and associations to enhance the quality of information available to this process.

The regulators could also contribute to accelerating the data enhancement by requiring accident year data by line of business. This requirement has been in effect for some time with the U.S.A. regulatory bodies.

G/ REVIEW OF ADEQUACY OF INDUSTRY RESERVE LEVELS

Appendices III and IIIA present the technical calculations to determine the undiscounted claims reserves using the only accident-year data available from the Federal Department of Insurance.

Two estimation methods are used, namely:

(i) incurred loss development; and
(ii) paid loss development.

Each of these methods is dependent on an historical consistency of individual case reserving philosophy, claim payment rates, claim reporting rates, etc.

While there is not sufficient detailed data available to completely validate the underlying consistency, Appendix III does present remarkable stability in the *Net Claims Incurred* development factors. The stability is evident throughout the history whereas the *Net Claims Paid* method only achieves stability after 48 months of development.

Appendix IIIA shows both methods indicating a substantial reserve deficiency at the end of 1984. Because of the above-noted superior stability, the incurred method is suggested as producing the more accurate result.

Consequently a deficiency of $956 million or 18.7% of total 1984 year-end stated reserves is indicated.

Measures of Adequacy

The most reliable measure of reserve adequacy is the "run-off test". This test takes a retrospective view of reserve levels of prior years and applies against those estimates all subsequent related payments and revised reserve judgments. If a surplus of prior reserve over related subsequent events exists, then prior years' reserves are judged to be excessive. If a deficiency results, then prior years' reserves have proven to be inadequate. (Refer to Appendix V for regulatory "run-off test form".)

The obvious shortcoming of this measure of adequacy is that it is strictly retrospective in nature. Any prospective test judging the adequacy of current reserve levels must be subjective in nature.

Regulators do not look to any specific test of reserve adequacy but rather form an opinion based on:

(i) results of previous year's run-off tests;

(ii) margin of capital and surplus to cover potential undetected errors in the current reserve levels. The Federal Insurance Act specifies in Section 103 that sufficient capital and surplus must be maintained to cover a 15% potential error in all stated reserves;

(iii) an actuarial report presenting an opinion of the reserve levels. It is apparent that regulators are relying on this opinion more than ever before.

H/ VARIABILITY OF RESERVING PROCEDURES AMONG COMPANIES

The industry-wide data used in Section G above reflects the position of the industry in total.

In an effort to illustrate the wide deviation of reserving methodologies and patterns between lines of business and companies, the graphs shown in Appendix II were created.

Commercial Liability

Y axis — claims reserves expressed as a percentage of premiums earned (by line of business) was used as a reserve indicator

X axis — 34 points, each representing one company-year

5 data lines — the reserve indicator for each company-year was sorted in ascending order by year

Source: 1985 TRAC Report (Exhibit 9)
Canadian Companies with at least $2,000,000 in reserves for each year 1980-84.

Conclusions:

(i) Commercial liability reserves have a wide range of levels among companies. In any one year the ratio of reserves to premiums may be in a minimum/maximum range of 100%-500%.

(ii) The range has increased markedly in the years 1984 and 1985.

(iii) Years 1980 and 1981 were reasonably stable in terms of this ratio. In 1982 there appears to have been a slight relaxation of reserve standards relative to premium levels. Years 1983 and 1984 show a very marked strengthening of reserves relative to premium levels.

Property

This graph is identical to Appendix IIA in every way except that property reserve indicators are shown instead of liability.

Conclusions:

(i) No identifiable trend of reserve strengthening or weakening is evident.

(ii) For most companies property reserve levels have increased/decreased at the same rate as premium levels.

(iii) Property reserves show a greater stability not only from one year to the next but also from one company to the other than is evident in commercial liability.

Table II below presents summarized data supporting these conclusions.

TABLE 2

VARIABILITY OF RESERVING METHODS BY LINE AND BY COMPANY SUMMARY

	1980	1981	1982	1983	1984
COMMERCIAL LIABILITY					
# of Companies in Survey	34	34	34	34	34
Industry Average Indicators	190	165	204	264	288
Standard Deviation of Individual Company Indicators	73	61	64	106	111
PROPERTY					
# of Companies in Survey	45	45	45	45	45
Industry Average Indicators (%)	40	38	36	34	36
Standard Deviation of Individual Company Indicators	14	13	17	15	16

I/ DISCOUNTING OF CLAIMS RESERVES

It is the practice of the property/casualty industry to determine claims reserves on an ultimate value basis (i.e., without any regard for the time value of money). To date both insurance regulators and tax officials have accepted this practice.

However, there can be no denying that claims reserves calculated on an ultimate basis do possess a "hidden equity".

For the purposes of this report, this "equity" shall be defined as the difference between the reserves as stated and the present value of the "actuarially indicated adequate reserves".

Appendix IV presents the technical calculations used in quantifying this "equity" for the all-industry data used in Section G above.

For convenience the pertinent assumptions and conclusions are presented below.

1) **Assumed Future Payout Stream**

First 12 months 51% of ultimate claims are paid
Next 12 months 24% of ultimate claims are paid
Next 12 months 6% of ultimate claims are paid
Next 12 months 4.3% of ultimate claims are paid
Next 12 months 3.4% of ultimate claims are paid

Next 12 months 3.1% of ultimate claims are paid
Next 12 months 2.7% of ultimate claims are paid
Next 12 months 2.3% of ultimate claims are paid
Next 12 months 3.8%* of ultimate claims are paid

*Factor of 3.8% is compound effect of continuing payments at a decreasing rate for 2-3 subsequent years. This calculation forces the payout to stop at 108 months.

2) **Interest Rates**

Results for rates of 8%, 10% and 12% are provided. The "least risky" interest rate would be that which results from purchasing fixed income instruments on a maturity schedule matching the payment rate assumed in 1) above.

This matching provides immunization against reinvestment risk yet provides sufficient liquidity for normal operations. It is assumed that this "least risky" rate would lie in the range of 8%-12%.

APPENDIX I

RECOMMENDATIONS FOR PROPERTY-CASUALTY INSURANCE COMPANY FINANCIAL REPORTING

(Approved by Council on September 12, 1985
for a Trial Period of One Year)

Canadian Institute of Actuaries/Institut canadien des actuaires

PART ONE

INTRODUCTION

1.01 **Institute Objectives**

Because it is desirable that actuarial information determined by a member for an insurance company's financial reporting

(a) be properly determined and

(b) be fully and clearly disclosed, with no withholding of material informations, favourable or unfavourable;

and because it is desirable that the determination and disclosure

(c) be in a form which permits the member's peers, if his conduct has been challenged, to make a judgment as to whether his conduct was in accordance with good actuarial practice; and

(d) merit the respect of and acceptance by the public and Superintendents of Insurance;

the Council of the Canadian Institute of Actuaries has approved the following Recommendations for conduct as valuation actuary of a property-casualty insurance company.

1.02 **Definitions**

CASE RESERVE

For a well-defined group of claims, the sum of estimates that have been placed on individual reported claims.

CIA RECOMMENDATIONS

These recommendations.

CLAIMS ADJUSTMENT EXPENSE RESERVE

The estimated amount needed to cover all future expenses required to investigate and settle claims incurred during a particular period. These expenses include internal and external claims adjustment expenses.

CLAIMS ADJUSTMENT EXPENSES

All expenses incurred in connection with the settlement of claims. This includes all external expenses incurred in the handling of claims as well as all internal claims expenses.

Internal expenses include all direct expenses of the claim department and any part of the general administration expenses assignable to the claim function.

CLAIMS LIABILITIES

The estimated amount which must be paid after the valuation date to settle all claims reported and unreported (including all adjustment expenses), which have occurred before the valuation date.

DEVELOPMENT

The difference, on successive valuation dates, between observed values of certain fundamental quantities which may be used in the claims reserve estimation process.

GOVERNMENT STATEMENT

The annual financial statement required to be deposited with the Superintendent of Insurance.

INCURRED BUT NOT REPORTED CLAIMS RESERVE (IBNR)

The reserve for claims incurred but not yet reported to the company. This reserve also includes claims that have been reported but not yet recorded.

POLICY LIABILITIES

The estimated amount which must be paid after the valuation date to service those policies in force as of the valuation date, including the settlement of future claims arising therefrom.

PROPERTY-CASUALTY INSURANCE COMPANIES

Those companies required to file form INS 52, INS 53 or their provincial equivalents.

PROVISION FOR DEVELOPMENT ON REPORTED CLAIMS

The provision necessary to compensate for the anticipated inadequacy or redundancy in case reserve.

SUPERINTENDENT OF INSURANCE

The federal or provincial Superintendent of Insurance having responsibility for administration of the Act under which the company is registered.

TABULAR RESERVES

Individual claims reserves valued using a mortality/morbidity table.

VALUATION DATE

The date as of which the reserves are evaluated.

1.03 Conformity with Recommendations

The member should conform to the CIA Recommendations, except in unforeseen circumstances which make them inappropriate. In those circumstances, he should consult with the Committee on Property-Casualty Insurance as soon as is reasonably possible.

Pending advice from the Committee, he should adapt the Recommendations to the circumstances and, when giving his opinion in accordance with Part 7, may regard the valuation as conforming to the Recommendations. The Committee should propose an appropriate change to the Recommendations if it agrees with the member that they are inappropriate. Pending action on that proposal by the Institute, a member who conforms with it is not thereby in breach of these Recommendations if his conduct is in accordance with good actuarial practice.

The Committee may, upon request, advise a member about the application of the CIA Recommendations.

1.04 Changes

These CIA Recommendations reflect the present state of actuarial practice and the insurance business. Institute policy is to change the Recommendations from time to time to take account of advances in actuarial science and the evolution of the insurance business. To that end, the Committee should actively seek changes in the Recommendations and propose them to Council.

1.05 Explanatory Notes

The Committee on Property-Casualty Insurance may distribute Explanatory Notes to the membership.

An Explanatory Note should amplify the CIA Recommendations or illustrate their application, but is not as such binding on any member.

1.06 Documentation

The member may be called upon to justify his work. He should therefore compile and retain documentation which enables him to show that he has conformed to the CIA Recommendations.

1.07 Approximations

An approximation to an assumption or method is acceptable where it reduces the cost of, or improves the member's control over, the valuation, but does not materially affect the result.

1.08 **Materiality**

A difference is material if it is significant to a user of the financial statements. The member should choose a standard of materiality which will reasonably satisfy each normal user of the financial statements.

PART TWO

DATA

2.01 **Introduction**

The member should be familiar with the procedures for the administration and accounting of the company's claims and policies.

The member should be conversant with the general characteristics of the insurance portfolio for which reserves are to be established. This would normally include familiarity with the contractual guarantees and obligations under policies in force as well as other attributes, such as deductibles, policy limits and reinsurance provisions, which may have a bearing on reserving.

For the evaluation of policy liabilities, the member should have information about the nature and timing of recent rate changes and the allocation of expenses by categories and lines of business.

2.01 **Data Availability and Reliability**

It is the member's responsibility to assure that the necessary data for the establishment of proper liabilities are available.

2.03 **Reconciliation With Other Data**

The member should verify the consistency of the valuation data with the company financial records.

PART THREE

CONSIDERATIONS FOR CLAIM LIABILITIES

3.01 **Introduction**

Claim reserving is fundamentally concerned with the estimate of ultimate loss and adjustment costs on unpaid claims.

Understanding the trends and changes affecting the data base is a prerequisite to the application of actuarially sound reserving methods. A knowledge of changes in underwriting, claims handling, data processing and accounting, as well as changes in the legal and social environment affecting the experience, is essential to the accurate interpretation and evaluation of observed data and the choice of reserving methods.

The establishment and evaluation of proper claim provisions is considerably improved by subdividing the entire claims experience into well-defined groups. Where possible, loss data which have been relatively unaffected by changes in company procedures and operations should be used. The possibility of subdividing or combining the data so as to increase its homogeneity or to minimize the distorting effects of underlying or procedural changes on the data should be fully explored.

3.02 **Homogeneity**

The member should strive to group together those claims exhibiting similar characteristics, such as comparable claim experience patterns, settlement patterns or size of loss distributions. For example, to the extent that the member is dealing with a heterogeneous product, such as commercial multi-peril or miscellaneous liability insurance, consideration should be given to breaking apart these products into more homogeneous groupings. Some other examples of specific considerations regarding homogeneity are the distinction between personal and commercial risks and the distinction between primary and excess coverage.

3.03 Credibility

The degree to which consideration is given to homogeneity is related to the consideration of credibility. Reliability is increased by proper homogeneous groupings on the one hand and by increasing the number of claims analyzed within each group on the other. Obtaining homogeneous groupings requires refinement and fragmentation of the total data base. Clearly, there is a point at which refinement scatters data into cells too small to provide reliable development patterns. Each situation requires a fresh balancing of the considerations of homogeneity and statistical reliability. Thus, line and coverage definitions suitable for the establishment of reserves in large companies can be in much finer detail than in the case of small companies. Where a very small group of claims is involved, use of external information such as industry aggregates may be necessary.

3.04 Emergence Patterns

The delay between the occurrence of claims and the recording of claims on the books of the company depends upon both the line of business and company practices. In general, property claims are reported quickly, whereas the reporting of liability claims may be substantially delayed. The member should continually review the claims handling procedure. Whenever a change in claims handling and recording procedures can be identified, experience should be adjusted to align it with the most recent practice.

3.05 Settlement Patterns

The length of time that it normally takes for claims to be settled will affect the choice of the loss reserving procedure. Claims arising under glass coverage, for example, tend to be settled quickly. On the other hand, bodily injury liability claims often require a long time to settle, even when reported immediately to the company. The ultimate amount of settlement depends on the interaction of more complex variables, such as the type and severity of the damage and the intricacies of the judicial process.

3.06 Development Patterns

The actuary often uses case reserves established by the claim department as a starting point in evaluating total claims liabilities. Therefore, substantial care should be given to reviewing the pattern of development on known cases. The company's claims handling procedures will affect the manner in which the case reserves change over time for any individual claim. Further, the length of time to settlement will affect the observed reserve development.

3.07 Frequency and Severity

The same total dollars of losses may arise from a few large claims or from many small claims. Claim liability estimates will tend to be more accurate for losses resulting from a high-frequency/low-severity group of claims than from a low-frequency/high-severity group of claims. Therefore much more care should be taken in analyzing low-frequency/high-severity groups of claims.

3.08 Reopened Claims Potential

The propensity for claims which were recorded as closed to reopen varies substantially among lines of business. Beyond this, precedent-setting judicial opinions and liberalizing legislation can affect the reopening of claims. Company procedures will also affect the potential for claims to be reopened. A time to be alert is when operating procedures (claims, data processing, accounting, etc.) are changing or emphasis is shifting.

3.09 Aggregate Limits

For certain insurance coverages, such as products and malpractice liability, aggregate limits will act to restrict total potential incurred losses and therefore claim liabilities. In reviewing groups of claims where aggregate limits apply, audit tests of the data will reveal to what extent limit ceilings have been reached, and in what respect reserve projections may have to be modified to take this factor into account. Proper attention should be paid to defence cost, which in many instances will not be limited by the aggregate limit.

3.10 Collateral Sources

For a proper evaluation of a company's total claim liabilities, the impact of salvage and subrogation on the group of claims under consideration should be included. In addition, the impact of coinsurance, deductibles, coordination of benefits, as well as any other collateral sources should be considered.

3.11 Reinsurance Cession

The member should know and consider the types of reinsurance plans and retentions currently in force. To the extent that current arrangements might differ from plans in effect during the claim experience period, the member should estimate the effect such differences might have on observed emergence and development patterns. Consideration should be given to the recoverability of money under reinsurance arrangements.

3.12 Pools and Associations

The total claim liabilities within an insurance company depend in some degree on forces beyond its control, such as business assumed or business obtained through participation in both voluntary and non-voluntary underwriting pools and associations. Nevertheless the member should be aware that the operating and reserving policies and loss development patterns of such business may be different from the insurer's own operation.

3.13 Operational Changes

It is the member's responsibility to review the existing business practices and to verify the continued applicability of past assumptions. The installation of a new computer system, an accounting change, a reorganization of claims responsibility or a change in an underwriting program in a company can affect the continuity of the loss experience. When such changes are observable and the effects are measurable, appropriate compensating adjustments should be made in the procedures for evaluating liabilities.

3.14 Changes in Loss Distribution

Losses may occur in all size ranges. Changes in contract provisions may limit or change the amount of actual claim against the insurance company through the use of deductibles, policy limits or the sale of excess coverage which excludes all of the primary layer of losses. Such contractual changes affect both the frequency and severity of actual claims. If the change has been occurring over time, such as in the case of a higher deductible being sold for a particular class of policies, attempts should be made to adjust past experience to reflect current circumstances.

3.15 External Influences

Due regard should be given to the impact of external influences. Specific considerations include the judicial environment, regulatory and legislative changes, residual or involuntary market mechanisms, and economic variables such as inflation.

It is not sufficient for the member merely to apply historical analytical procedures in the calculation of reserves. Whenever the impact of internal or external changes on claim data can be isolated or reasonably quantified, adjustment of the data is warranted before applying various reserving methods. Whenever possible, the assumptions underlying each method should be tested statistically. It may be possible to adjust historical data so that the underlying assumptions are more nearly satisfied.

3.16 **Claim Reserving Techniques**

The two principal strategies usually employed are the report period approach and the accident period approach. When a report period approach is used, an attempt is made to measure the upward or downward development on claims which have already been reported to the company and to use that measurement to estimate the aggregate reserve redundancy or deficiency on those claims. To determine IBNR, additional analysis by accident period is required in order to measure the emergence of IBNR.

When a pure accident period approach is used, report dates are ignored and an attempt is made to estimate directly the ultimate cost of all claims, whether reported or not, arising from accident periods prior to the valuation date. This approach results in an estimate of the total claim liability. The total claim liability is then apportioned between provisions for IBNR and known claims on a suitable basis.

The use of accident period techniques can, under certain circumstances, lead to a seemingly broader definition of IBNR than is used in these Recommendations. If, for instance, an accident period approach has been used to estimate directly the total claim liability and IBNR is obtained simply by subtracting the case reserve from the total, the provision for future development on known claims will automatically be included with IBNR. In these circumstances the provision for reopened claims will also be included with IBNR.

Detailed discussion of the technology and applicability of current claim reserving practices is beyond the scope of these Recommendations. Selection of the most appropriate method of reserve estimation is the responsibility of the member. A member will ordinarily examine the indications of more than one method before arriving at an evaluation of an insurer's liability for a specific group of claims.

PART FOUR

CONSIDERATIONS FOR POLICY LIABILITIES

4.01 **Introduction**

Policy liabilities are the anticipated costs for servicing the unexpired portion of the policies in force. These liabilities include a provision for future claims and a provision for future expenses.

4.02 **Annual Statement Treatment**

Policy liabilities are not shown explicitly on the annual statement but are the net total of the unearned premium reserve, deferred acquisition expenses and/or premium deficiency. The member should determine policy liabilities in total and the unearned premium.

If the policy liabilities are less than the unearned premium, the difference should be shown as Deferred Acquisition Expenses. However, the Deferred Acquisition Expenses should not be greater than the "unearned" portion of acquisition expenses.

If the policy liabilities are greater than the unearned premium the difference should be shown as a premium deficiency.

4.03 Premium Level

The estimated claim ratios of the unexpired policies should be evaluated in light of the results of current and previous years, taking into account the changes in average premium level.

4.04 Trend Factors

Appropriate trend factors should be applied to past and current claim ratios in order to evaluate the claim level for the unexpired portion of the policies in force. The trend factors will generally be consistent with those used in the ratemaking process.

4.05 Seasonality of Losses

The nature (frequency and severity) of claims tend to vary according to season. As the unexpired portion of the in-force policies has a much heavier exposure in the first half of the coming year, such effect has to be evaluated.

PART FIVE

METHODS AND ASSUMPTIONS

5.01 Appropriateness

Each method and assumption should be appropriate to the circumstances of the company and the policies in force.

5.02 Change in Assumptions

The member should choose methods and assumptions which are appropriate at the valuation date, except that he need not change from those of the prior valuation unless the effect of the change is material. The member's standard of materiality should be more rigorous for a change which increases liabilities and less rigorous for a change which decreases them.

The member should not spread the effect of a change in method or assumption over more than one valuation.

5.03 Disclosure of Effect of Change

Where (i) the methods or assumptions differ from those in the prior valuation, and (ii) the difference is material at the current and prior valuation dates, then the effect of the change on the current accounting statements shall be disclosed.

5.04 Provision for Adverse Deviations

It is not possible to determine total liabilities with complete confidence. In evaluating liabilities, consideration should be given to the insurer's responsibilities to policyholders and claimants, as well as the inherent variability of conditions affecting future claim payments.

Such consideration will result in the estimation of liabilities on a conservative basis. The degree of conservatism is a matter of actuarial judgment and depends upon the following factors:

1. the member's confidence in the expected development pattern;
2. the time period over which the liabilities will extend;
3. the statistical fluctuations affecting claims development and reporting pattern; and
4. the quality and depth of historical data on the basis of which the reserve liabilities are evaluated.

Provision for adverse deviation needs not to be explicit; estimates may be conservative due to the member's selection of methodology and assumptions.

The member should not make provision in the liabilities for abnormal adverse deviations.

5.05 Discounting Claim Liabilities

When establishing provisions, the following guidelines should be used concerning the discounting of claim liabilities:

a. claims are not customarily discounted for anticipated investment earnings between the date of claim and the date of settlement, except for tabular reserves;
b. short-term claims and long-term uncertain amount claims may be discounted in the aggregate provided the impact is material and sufficient provision for adverse deviation has otherwise been included;
c. where provisions are discounted, the undiscounted provision shall also be calculated for the purpose of testing runoff patterns.

5.06 Investment Return

When discounting provisions, the member should base his investment return on what he expects the portfolio to earn net of investment expenses.

The following factors should be considered:

1. methods of reporting investment income and of valuing assets in the annual statement;
2. allocation of investment income to surplus and among lines of business and years of investment; and
3. the earnings of the current portfolio.

5.07 Reasonableness

The member has a responsibility to consider the reasonableness of the indications produced by the evaluation procedures employed. The incurred losses implied by the provisions should be measured against relevant parameters, such as premium, exposures or number of policies, and expressed wherever possible in terms of frequencies, severities and loss ratios. No material departure from past results should be accepted without attempting to find an explanation for the variation.

PART SIX

THE ACTUARY'S REPORT IN PUBLISHED FINANCIAL STATEMENTS

6.01 Application

This part applies where a statement of the property-casualty valuation actuary's opinion is included in the annual financial statements for:

a. the global operations of a Canadian insurance company registered under the *Canadian and British Insurance Companies Act*;
b. the global operations of a Canadian insurance company registered under a provincial statute designated by Council; or
c. the Canadian operations of a British insurance company registered under the *Canadian and British Insurance Companies Act*, or of a foreign insurance company registered under the *Foreign Insurance Companies Act*, where a balance sheet is included;

and are presented at its annual meeting in Canada or intended for the information of the Canadian shareholders, policyholders, or general public.

6.02 Text of the Report

The following is recommended for the financial statements of an insurance company which include an income statement and which do not involve consolidation of a foreign subsidiary:

REPORT OF THE PROPERTY-CASUALTY VALUATION ACTUARY

> I have made the valuation of the *policy and claims liabilities* of the *XYZ Insurance Company* for its balance sheet at *31 December 19.. and its income statement* for the *year* then ended. In my opinion (i) the valuation conforms to the Recommendations for Property-Casualty Insurance Company Financial Reporting of the Canadian Institute of Actuaries; (ii) the amount of the policy and claims liabilities makes proper provision for the future payments under the company's policies; and (iii) a proper charge on account of those *liabilities* has been made in the *income statement*.

The member should delete the references to income statements where the financial statements do not include one. The member should adapt the [italicized] words to his situation but make no other change.

Where there is a consolidated foreign insurance subsidiary, the member should adapt the following model to his situation:

REPORT OF THE VALUATION ACTUARY

> I have made the valuation of the *policy and claims liabilities* of the *Parent Insurance Company* for its *consolidated balance sheet at 31 December 19..* and its *consolidated income statement* for the year then ended. In my opinion, the valuation for *Parent Insurance Company* conforms to the Recommendations for Property-Casualty Insurance Company Financial Reporting of the Canadian Institute of Actuaries. *I have relied upon the valuation made by the actuary of the subsidiary company.* In my opinion, (i) the amount of the policy and claims liabilities makes proper provision for future payments under the the company's policies, and (ii) a proper charge on account of those *liabilities* has been made in the *consolidated income statement*.

6.03 **Signing**

In signing the opinion, the member should identify his connection with the company. He should identify himself as a Fellow of the Canadian Institute of Actuaries or F.C.I.A.: he may also append other professional qualifications.

6.04 **Filing**

The member should file a copy of his report with the auditor, where one has been appointed to report on the published financial statements, and a copy with the Board of Directors. The filing should set forth the amounts which the member determined.

6.05 **Disclosure Notes**

The note for a situation in section 6.06 should:

a. describe the situation;
b. state its effect on liabilities, surplus, and net income for the current year and each past year reported on in the financial statements; and
c. indicate its projected future financial effect.

The note should be as short as possible. It should use the ordinary dictionary meaning of words and avoid jargon.

Matters covered by a note which do not lend themselves to an unqualified assertion of fact should be qualified by words like "in the opinion of the property-casualty valuation actuary".

6.06 Disclosure Situations

The member should not sign the report unless he has reason to believe that the financial statements will include a note drafted according to section 6.05 and covering each of the following situations which is applicable:

a. The assumptions or methods differ from those in the prior valuation and (i) the difference applies to policies having material policies and claims liabilities at the prior valuation; and (ii) the effect of the difference is material at the valuation or is expected to be material afterwards. The member may use a standard of materiality less rigorous than that used for the purpose of section 5.02.
b. The member cannot in conscience say that the data are "sufficient and reliable", that the assumptions are "adequate and appropriate", and that the methods are "consistent with sound actuarial principles", as set forth in item 4.(b) of the Guides to Professional Conduct. The member should, however, try to avoid this situation.
c. Since the prior valuation, the company has taken an action or adopted a practice which materially alters the timing of emergence of income or surplus.
d. Between the valuation date and the date he signs the report, the member becomes aware of information emerging or an event occurring whose financial implications are themselves material and also materially at variance with the valuation.
e. The member considers any other aspect of an actuarial nature to be relevant to fair presentation.

6.07 Implications of Report Language

This section considers some of the professional implications of the text in section 6.02.

"I have made the valuation. . ." The report includes an opinion of an actuarial determination by the member, not an opinion about a review of a determination by another actuary.

The member may delegate a substantial part of the work to other persons who act under his technical supervision. The member, however, takes responsibility for the results and he should have enough control over the work to meet that responsibility.

"Policy and claims liabilities. . ." In the case of policy liabilities this covers the net of unearned premiums and deferred policy acquisition expenses or premium deficiencies and in the case of claims liabilities unpaid claims and adjustment expenses as used on the annual statement. These items should appear separately on the balance sheet so they can be identified.

The member should not reduce the responsibility taken in his report simply because the auditor in his report is taking responsibility for one or more of the policy and claims liabilities.

"In my opinion. . ." These words are needed because an actuarial determination does not lend itself to an unqualified assertion of fact. However, the words are a disclosure, not an escape clause. They mean, "I hereby certify that in my considered opinion as a professional actuary. . ."

". . . proper provision. . ." is more than barely sufficient. It is a good and sufficient provision determined from:

a. adequate and appropriate assumptions, and methods consistent with sound actuarial principles, as described in these Recommendations and in the actuarial literature, or

b. where more rigorous, applicable statutory requirements.

"...future payments..." include both amounts incurred before and amounts incurred after the valuation date.

"...proper charge...in the income statement". The charges does not appear as a separate number in the income statement.

PART SEVEN

THE REPORT BY THE PROPERTY-CASUALTY VALUATION ACTUARY IN THE GOVERNMENT STATEMENT

7.01 **Application**

This part applies where a member prepares the valuation actuary's report for a government statement of:

a. an insurance company registered under the *Canadian and British Insurance Companies Act*, or
b. an insurance company registered under a provincial statute designated by Council.

7.02 **Footnoted Reserves**

The member should describe his method of establishing these reserves.

7.03 **Disclosure Situations**

For each of the situations in items a. through e. of section 6.06, the member should

a. describe the situation;
b. state its effect on reserve, surplus and net income for the current year and the prior year; and
c. indicate its projected future financial effect.

7.04 **Drafting the Report**

Matters in the report which do not lend themselves to an unqualified assertion of fact should be qualified by words like "in my opinion".

The member may use terminology and formulae which will be understood by another actuary, but which need not necessarily be understood by a layman.

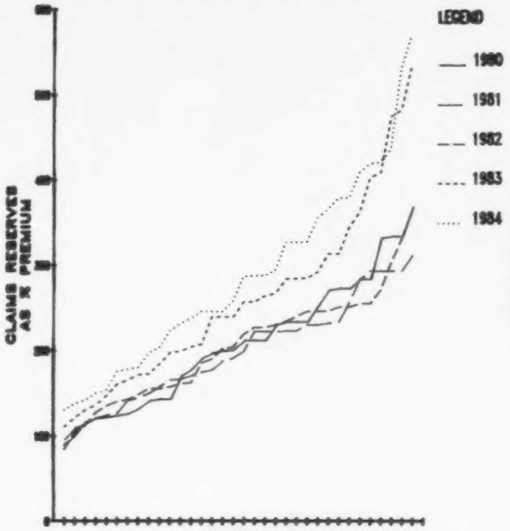
When the member uses a term defined in the CIA Recommendations, it is understood to have the same meaning unless he otherwise specifies.

EXPLANATORY NOTE — 3.11 REINSURANCE CESSION

This recommendation calls for familiarity on the part of the member with all reinsurance ceded arrangements which might have an effect on net outstanding claims because of potential recoveries from reinsurers. The last sentence requires that consideration be given to the recoverability of money under any such arrangements.

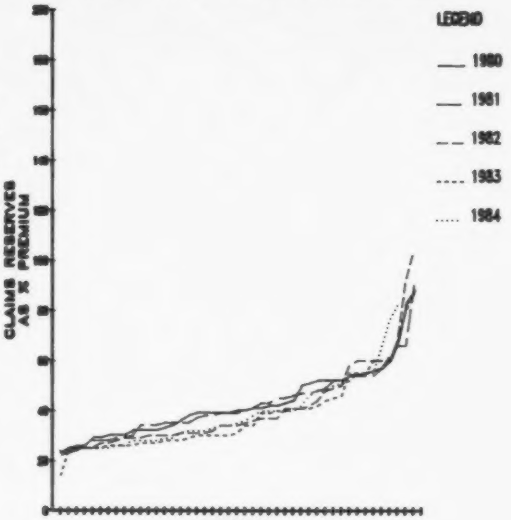
Due recognition should be given to readily available information which might cast doubt on the financial stability of reinsurers to whom business has been ceded. Nonetheless the scope of the member's responsibility under this section would normally be limited to determining the amount of the net claims liabilities. Detailed assessment of the financial condition of all companies to whom reinsurance has been ceded would be beyond the scope of the actuary's responsibility.

COMMERCIAL LIABILITY
RESERVE VARIABILITY
AMONG 34 CANADIAN COMPANIES



THE Wyatt COMPANY

PROPERTY
RESERVE VARIABILITY
AMONG 45 CANADIAN COMPANIES



THE Wyatt COMPANY

APPENDIX III

***TOTAL BUSINESS IN CANADA** **ALL COMPANIES COMBINED**

CLAIMS DEVELOPMENT **DEVELOPMENT FACTORS**

NET CLAIMS OUTSTANDING ($000)

Accident Year	12 MOS	24 MOS	36 MOS	48 MOS	60 MOS
1980	1,753,514	735,089	512,494	400,255	300,873
1981	2,003,569	820,844	650,811	531,804	
1982	1,950,302	936,380	750,577		
1983	2,145,516	1,035,812			
1984	2,490,483				

NET CLAIMS PAID ($000)

Accident Year	12 MOS	24 MOS	36 MOS	48 MOS	60 MOS
1980	1,995,238	3,006,504	3,261,348	3,431,634	3,568,133
1981	2,334,630	3,470,531	3,738,485	3,949,400	
1982	2,542,829	3,532,563	3,822,149		
1983	2,306,427	3,402,935			
1984	2,646,256				

NET CLAIMS PAID

Accident Year	24:12	36:24	48:36	60:48
1980	1.507	1.085	1.052	1.040
1981	1.487	1.077	1.056	
1982	1.389	1.082		
1983	1.475			
1984				
MEAN	1.465	1.081	1.054	1.040

NET CLAIMS INCURRED ($000)

Accident Year	12 MOS	24 MOS	36 MOS	48 MOS	60 MOS
1980	3,748,752	3,741,593	3,773,842	3,831,889	3,869,006
1981	4,338,199	4,291,375	4,389,296	4,481,204	
1982	4,493,131	4,468,943	4,572,726		
1983	4,451,943	4,438,747			
1984	5,136,739				

NET CLAIMS INCURRED

Accident Year	24:12	36:24	48:36	60:48
1980	0.998	1.009	1.015	1.010
1981	0.989	1.023	1.021	
1982	0.995	1.023		
1983	0.997			
1984				
MEAN	0.995	1.018	1.018	1.010

*Source: Federal Department of Insurance

APPENDIX IIIA

Review of Adequacy of Industry Reserve Levels
All Canada (Federal Companies)/All Lines
(Refer to Appendix III for background detail)

Estimate of Ultimate Claims Amounts (000)

	Incurred Method		Paid Method	
Accident Year	Factor	Estimated Ultimate Cost	Factor	Estimated Ultimate Cost
1980	1.00	$ 3,869,006	1.14	$ 4,067,672
1981	1.01	4,889,616	1.18	4,660,292
1982	1.028	4,700,762	1.25	4,777,686
1983	1.047	4,647,368	1.35	4,593,962
1984	1.041	5,347,345	1.97	5,213,124
Total Estimate		$23,454,097		$23,312,736
Total Accounted For		22,498,422		22,498,422
– Reserve Excess (Deficiency)		(955,675)		(814,314)
– Excess (Deficiency) as % of Stated Reserves		(18.7%)		(15.9%)

APPENDIX IV

ALL CANADA-ALL LINES
FEDERALLY REGISTERED PROPERTY/CASUALTY INSURERS
ASSESSMENT OF DISCOUNTED RESERVES AT DECEMBER 31, 1984

		Payment Rate-Maturity Point (Months)									
Line of Business		12	24	36	48	60	72	84	96	108	
All Lines-All	Dev't fac	1	1.465	1.081	1.054	1.04	1.035	1.03	1.025	1.04	
Federal Companies	Cum've	1	1.465	1.583665	1.669182	1.735950	1.796708	1.850609	1.896874	1.972749	
	Payment	1	0.465	0.118665	0.085517	0.066767	0.060758	0.053901	0.046265	0.075874	
	Sum		0.92749	0.507749	0.389084	0.303567	0.236799	0.176041	0.122140	0.075874	
Year	**Maturity Level**	**Reserves**	**1986**	**1987**	**1988**	**1989**	**1990**	**1991**	**1992**	**1993**	**Total**
1980	60	300873	77198	68486	58784	96405	0	0	0	0	300873
1981	48	940216	206794	188182	166944	143294	235002	0	0	0	940216
1982	36	878613	193112	150771	137201	121717	104474	171337	0	0	878613
1983	24	1244433	290833	209594	163639	148911	132105	113390	185960	0	1244433
1984	12	2701089	1291191	329504	237462	185397	168711	149671	128467	210686	2701089
		6065224	2059129	946536	764030	695724	640292	434398	314428	210686	6065224
			0.5	1.5	2.5	3.5	4.5	5.5	6.5	7.5	
Present Value Factors											
	8%		0.962250	0.890972	0.824974	0.763865	0.707282	0.654891	0.606381	0.561463	
	10%		0.953462	0.866784	0.787985	0.716350	0.651227	0.592025	0.538204	0.489277	
	12%		0.944911	0.843670	0.753277	0.672569	0.600508	0.536167	0.478721	0.427429	
Discounted Reserves											
	8%	5032788	1981398	843338	630306	531439	452868	284484	190663	118293	
	10%	4830634	1963302	820443	602045	498382	416976	257175	169226	103084	
	12%	4645696	1945694	798565	575527	467922	384501	232910	150523	90054	
Amount of Discount											
	–8%	1032436									
	–10%	1234590									
	–12%	1419528									

Name of Company 19

EXHIBIT 34 – NET CLAIMS AND ADJUSTMENT EXPENSES – TOTAL REVIEW OF CLAIMS SETTLEMENTS AND UNPAID AMOUNTS REPORTED IN PREVIOUS ANNUAL STATEMENTS

(01)		19 and prior years (02) $'000	19 (03) $'000	19 and prior (02) + (03) (04) $'000	19 (05) $'000	19 and prior (04) + (05) (06) $'000	19 (07) $'000	19 and prior (06) + (07) (08) $'000	19 (09) $'000	19 and prior (08) + (09) (10) $'000	19 (11) $'000	19 and prior (10) + (11) (12) $'000	
Unpaid amounts, Dec. 19	.01												
Paid during 19	.02												
Unpaid amounts, Dec. 19	.03												
Excess or (Deficiency)	.04												
Ratio	.05												
Paid during 19	.06												
Unpaid amounts, Dec. 19	.07												
Excess or (Deficiency)	.08												
Ratio	.09												
Paid during 19	.10												
Unpaid amounts, Dec. 19	.11												
Excess or (Deficiency)	.12												
Ratio	.13												
Paid during 19	.14												
Unpaid amounts, Dec. 19	.15												
Excess or (Deficiency)	.16												
Ratio	.17												
Paid during 19	.18												
Unpaid amounts, Dec. 19	.19												(a)
Excess or (Deficiency)	.20												
Ratio	.21												

(Lines 18 + 19) 22

Excess or Deficiency: Opening unpaid amounts as shown at head of column less total amounts paid to excess or deficiency date less unpaid amounts at excess or deficiency date. 23 (b)

Ratio: Excess or deficiency divided by unpaid amounts at the head of the column. 24 (c)

(a) Including a total of $'000 for incurred but not reported claims, allocated as follows:

(25) 19 : $ (current year) 19 : $ (1st prior year)
(26) 19 : $ (2nd prior year) 19 : $ (3rd prior year)
(27) 19 : $ (4th prior year) 19 : $ (5th and all prior years)

(b) Deduct unpaid amount for previous year, line 15, column 10.

(c) This total should include the amount shown on line 15, column 01, Exhibit 43, Adjustment Expenses and should be the same as that amount shown on line 08, column 01, Exhibit 3, Statement of Income.

APPENDIX 9

TASK FORCE ON THE INSURANCE INDUSTRY ONTARIO AND CANADA: OVERVIEW OF THE REGULATION OF INSURANCE

April, 1986

M. Elizabeth Atcheson
Cassels, Brock & Blackwell

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TASK FORCE ON THE INSURANCE INDUSTRY ONTARIO AND CANADA: OVERVIEW OF THE REGULATION OF INSURANCE

INTRODUCTION

The purpose of this paper is to identify the principal features of Canadian and Ontario laws governing insurance. Looking back over a century of regulation, one is struck by the dearth of published materials analyzing the policies behind the provisions and the provisions themselves in operation. Innovation has been rare: change has occurred gradually and, to some degree, sparingly. The principal features of the regulatory scheme were established early in the century and have weathered the turbulence resulting from pressures and changes caused by competition and consumer demand.

The history of statutory amendments suggests that insurance regulation has been highly reactive to changes in the marketplace and, more specifically, to *abuses* in the marketplace. The regulation would appear to have been less interventionist than many might think.

Insurance corporations, while they have not to date had the legal status of natural persons, nonetheless have had considerable range in which to execute their objects. The statutes illustrate overriding concern with stability, solvency and the results of unequal bargaining power amongst contracting parties. Most significant changes touched on these matters. Apart from automobile insurance, however, there is very little rule-making associated with developments in the design of products or the terms of availability of such products, particularly with respect to property-casualty insurance products. For these reasons, it is difficult (if not impossible) to track changes in the insurance marketplace with changes in insurance regulation.

In fact, there appears to have been a long-standing aversion to *detailed* rule-making (including enforcement procedures), even with respect to stability and solvency matters. In the regulatory context, that choice is like a sword which cuts both ways. It gives the regulator wide, *de facto* power to deal with a known problem company through a combination of negotiation and direction (a form of "moral suasion"). In the case where a problem is either difficult to detect or (on the other extreme) systemic, the Superintendent's *de jure* remedial powers may be cumbersome (because of built-in procedural safeguards for the affected party) or inadequate.

To some extent, the debate about breaking down the separate identities of the "four pillars" has obscured critical regulatory questions about how to predict and control negative change (e.g., insolvencies) while facilitating positive change (e.g., networking). These questions, however, would be on the public agenda even if the current capacity and cost cycle in the property-casualty industry were not occurring.

The rate of change in the regulatory system generally has simply not met the rate of change (negative and positive) in the industry, with resulting disequilibrium. The current proposals for amendment (Bill 108 in Ontario and the federal Superintendent of Insurance's memorandum) are remedial and continue the tradition of limited "patchwork" (albeit needed) amendments. There does not appear to be a consensus (looking at the Dupré Report and the Blenkarn Report, in particular) on either an overhaul of the regulatory system or on fundamental features of corporate governance. There is no question that a complicating factor is the split constitutional jurisdiction over insurance matters, as well as the international nature of the industry (and particularly the property-casualty industry).

The record shows that we are not in a period of significant regulatory change where we can identify and measure successes and failures. While many strains on property-casualty insurers are unrelated to questions of regulation and governance, public confidence in the regulatory system is a critical, perhaps intangible factor in public confidence in property-casualty insurers.

1.0 THE CONSTITUTIONAL FRAMEWORK

1.1 Power to Incorporate Domestic Companies

1.1.1 The *Constitution Act, 1867* (30 and 31 Victoria, c.3, as amended by the *Constitution Act, 1982*, Schedule B to the *Canada Act 1982* (U.K.) 1982, c.11) which governs the distribution of powers between the federal and provincial governments, provides:

> 92. In each Province the Legislature may exclusively make Laws in relation to Matters coming within the Classes of subject next hereinafter enumerated; that is to say,— . . .
>
> 11. The Incorporation of Companies with Provincial Objects . . .

1.1.2 The Act, however, does not contain a similar power for Parliament, with the result that the federal power to incorporate has been held by the courts to derive from the residual power of Parliament as follows:

> 91. It shall be lawful for the Queen, by and with the Advice and Consent of the Senate and the House of Commons, to make Laws for the Peace, Order and good Government of Canada, in relation to all Matters not coming within the Classes of Subject by this Act assigned exclusively to the Legislatures of the Province. . . .

See: *Citizens Insurance Co. v. Parsons* (1881), 7 A.C. 96, at pp. 116-117, per Smith, J. (J.C.P.C.).

1.1.3 It is necessary to determine when a company is incorporated for "provincial objects". On the one hand, it is clear that a federal company may exercise its powers in one province only so long as the company was incorporated with powers to carry out business across Canada (*The*

Colonial Building and Investment Association v. The Attorney-General of Quebec (1883), 9 A.C. 157). On the other hand, a provincial company also may carry on business outside the province in which it was incorporated. The courts have held that a provincial corporation has the capacity to accept extra-provincial powers and rights unless its charter provides otherwise (*Bonanza Creek Gold Mining Company, Limited v. The King et al.* (1916), 1 A.C. 566, at pp. 583-84, per Haldane, J. (J.C.P.C.)).

1.2 Power to Licence Foreign Companies

Parliament has power under section 91 (under the heads of power pertaining to trade and commerce — 91(2) — and aliens — 91(25)) of the *Constitution Act, 1867*, to require a foreign company to obtain a licence from federal authorities. Again, this is so whether the foreign company will be operating in a single province only. See: *Attorney-General for Canada v. Attorney-General of Alberta and Attorney-General of British Columbia* (1916), 26 D.L.R. 288, at p. 291, per Haldane, J. (J.C.P.C.).

1.3 Power to Regulate the Business of Insurance

1.3.1 Neither section 91 nor 92 of the *Constitution Act, 1867*, refers specifically to insurance or contracts of insurance.

1.3.2 The courts consistently have held that the regulation of the business of insurance, including contracts of insurance, is solely within the jurisdiction of the provinces under subsection 92(13), "Property and Civil Rights in the Province". See: *Attorney-General for Ontario and Reciprocal Insurers and Others* [1924] A.C. 328, at p. 346 per Duff, J.

1.4 Federal-Provincial Relationships

The disputes about the powers of the two levels of government with respect to the regulation of insurance entities and business spanned a period of decades early in this century. In 1931, one member of the Judicial Committee of the Privy Council, Viscount Dunedin, remarked in frustration: "This case is, it may be hoped, the last of the series of litigations between the Dominion and the provinces with regard to insurance". (*Attorney-General for Quebec v. Attorney-General for Canada* [1932], 1 D.L.R. 97, at p. 100).

In 1917, provincial Superintendents formed "The Association of Provincial Superintendents of Insurance of the Dominion of Canada" as a forum to discuss ways and means to secure uniformity in the laws relating to contracts of insurance. In more recent years, the federal Superintendent of Insurance has participated in the Association, joining it officially only in 1985. It is now known as the "Canadian Council of Superintendents of Insurance".

2.0 REGULATION OF INSURANCE IN ONTARIO: HISTORICAL HIGHLIGHTS

2.1 The business of insurance in Ontario has been subject to regulation by statute for well over a century. The principal features of today's regulation can be identified in the early statutes, several of which were consolidated in the *Ontario Insurance Act* (60 Vict. c.36, which appeared without change as R.S.O. 1897, c.203).

2.2 The 1897 Act reinforced the established separate identity of insurance corporations by providing that:

> 54. No insurance other than as enacted by and for the purposes of the *Land Titles*

> *Act*, and any other contracts of guarantee undertaken by a company standing registered under the *Loan Corporations Act*, shall be transacted or undertaken in Ontario except by a corporation duly registered as herein provided. . . .
>
> 85. (1) After the 31st day of December, 1892, no person or persons, or body corporate or unincorporated, other than a corporation standing registered under this Act and persons duly authorized by law and by such registered corporation to act in its behalf, shall undertake or effect, or offer to undertake or effect any contract of insurance. . . .

"Insurance" was defined inclusively:

> 1.-41. "Insurance" shall include the following, whether the contract be one of primary insurance, or of reinsurance, and whether the premium payable be a sum certain, or consist of sums uncertain or variable in time, number or amount—
>
> (a) Insurance against death, sickness, infirmity, casualty, accident, disability, or any change of physical or mental condition;
>
> (b) Insurance against financial loss; or against loss of work, employment, practice, custom, wages, rents, profits, income or revenue;
>
> (c) Insurance of property against any loss or injury from any cause whatsoever, whether the obligation of the insurer is to indemnify by a money payment, or by restoring or reinstating the property insured;
>
> (d) Contracts of endowment, assessment-endowment, tontine, semi-tontine, lifetime benefits, annuities on lives, or contracts of investment involving tontine or survivorship principles for the benefit of persisting members; or any contract of investment involving life contingencies;
>
> (e) Any contract made on consideration of a premium and based on the expectancy of life; or any contract made on such consideration and having for its subject the life, safety, health, fidelity, or insurable interest of any person, whether the benefit under the contract is primarily payable to the assured or to a donee, grantee or assignee, or to trustees, guardians, or representatives, or to (or in trust for) any beneficiary, or to the assured by way of indemnity or insurance against any liability incurred by him or through the death or injury of any person;
>
> (f) Any investment contract under which lapses or payments made by discontinuing members or investors accrue to the benefit of persisting members or investors, except where a corporation (other than an insurance corporation) is expressly authorized to undertake such contract by a statute in force in Ontario;
>
> (g) Generally any contract in the nature of any of the foregoing whereby the benefit under the contract accrues payable on or after the occurrence of some contingent event.

The 1897 Act governed, for example, the incorporation of joint-stock companies (including the minimum capital stock required); the formation and incorporation of mutual and cash-mutual fire insurance companies and friendly societies; the requirement to be licensed and to make a deposit before being registered; the requirement to keep books, to have an annual audit[1] and to file annual statements; the requirement that each company be inspected periodically and the remedies for deficiencies; the limitation of investments to permissible investments; and liquidation. The 1897 Act included certain provisions on contracts of insurance, including specific provisions on insurance of the person and fire insurance.

2.3 From 1897 on, the Act was amended virtually every year until 1979 and it was restated entirely from time to time. The 1897 Act was repealed and replaced by the *Ontario Insurance Act, 1912* (S.O. 1912, c.33). It incorporated (section 15) a 1902 amendment (S.O. 1902, c.12, section 22) which restricted the formation of new municipal fire mutual insurance companies to the situation where it could be shown to the satisfaction of the Minister that a municipality did not have adequate provision for insurance on the mutual plan against fire. It also added a new provision governing brokers' licences for business with unregistered foreign corporations as follows:

> 100.- (1) Where the Minister is of the opinion that insurance or sufficient insurance of property cannot be obtained with registered insurers at ordinary or reasonable rates of premium, he may from time to time by license made for a term not in any case extending beyond the new insuring 30th day of June, authorize an insurance broker . . . to effect such insurance with insurers approved by the Minister not registered under this Act, and not transacting business in Ontario . . . .

A monthly reporting requirement was imposed on the licensee.

The 1912 Act also made it more difficult for non-Canadian incorporated companies to become licensed in Ontario. Such a company had to prove to the satisfaction of the Minister that it had carried on elsewhere successfully for at least five years the same type of business for which it sought a licence in Ontario (S.O. 1912, c.33, section 65)[2]. The audit requirement was removed and replaced by a provision authorizing the Minister to nominate a person to conduct one from time to time. (R.S.O. 1927, c.222, s-s. 69(2)).

Contracts of livestock insurance and weather insurance (previously regulated under separate statutes) were incorporated in separate parts in the 1912 Act.

2.4 Automobile insurance was added in 1914 (R.S.O. 1914, c.183, as amended by S.O. 1914, c.30, sections 2 to 4). Agents and underwriters' agencies also were regulated for the first time in 1914 (S.O. 1914, c.30, sections 5 and 6).

2.5 In 1922, the Act was amended to include detailed provisions on accident insurance and automobile insurance, including statutory conditions (S.O. 1922, c.61, sections 12 and 14, respectively). A new part was added to the Act governing agents, brokers and adjusters (section 16), as well as one on rates and rating bureaus (section 17). Further, a separate Act governing reciprocal or inter-insurance was enacted (S.O. 1922, c.62). It provided that:

> 3. It shall be lawful for any person to exchange with other persons in Ontario and elsewhere reciprocal contracts of indemnity or inter-insurance for any class of insurance for which an insurance company may be licensed under the provisions of the *Ontario Insurance Act* except life insurance, accident insurance, sickness insurance and guarantee insurance.

2.6 The *Ontario Insurance Act, 1924* (S.O. 1924, c.50) restated the 1914 Act, with amendments, and added some innovations to the regulatory scheme. First, it categorized (subsection 23(1)) the types of insurance companies in the manner still in use. Second, it provided that licences would be granted for classes of insurance, which were listed (subsection 24(1)). Interestingly, the minimum amounts of capital required to be subscribed and paid generally were lowered (subsection 25(1)). Two new parts of the Act were added pertaining to fraternal societies and mutual benefit societies. Overall, the most striking feature of the 1924 Act is the resemblance that it bears to the current legislation. The 1924 Act was reenacted by R.S.O. 1927, c.222, at which point it became known as the *Insurance Act*.

2.8 Aviation insurance was added as a class of insurance in 1929 (S.O. 1929, c.53, subsection 2(1)).

2.9 The principal revisions in 1930 established the Superintendent's authority to require that the companies carrying on the business of automobile insurance file information on premiums, losses and expenses (S.O. 1930, c.41, section 2). Whereas in 1922 the Act was amended to prohibit discrimination in rates, in 1930 the Superintendent was given power to intervene to adjust rates (section 12):

> 275a.- (1) It shall be the duty of the Superintendent after due notice and a hearing before him, to order an adjustment of the rates for automobile insurance, whenever it is found by him that any such rates are excessive, inadequate, unfairly discriminatory, or otherwise unreasonable.
>
> (2) Any order made under this section shall not take effect for a period of ten days after its date, and shall be subject to appeal within that time by any insured, insurer or rating bureau, in the manner provided by section 12 of this Act and, in the event of an appeal, the order of the Superintendent shall not take effect pending the disposition of the appeal.
>
> (3) The Attorney General shall be served with notice of any such appeal and shall be entitled to be heard by counsel upon the hearing thereof.
>
> (4) Any rating bureau, insurer or other person failing to comply with any provision of such order shall be guilty of an offence.

2.10 In 1932, the automobile part of the Act was repealed and replaced (S.O. 1932, c.25, section 2). Thereafter, amendments were made to the Act on a regular basis and were consolidated in succeeding revisions (R.S.O. 1937, c.256; R.S.O. 1950, c.183; and R.S.O. 1960, c.190).

2.11 In 1947, the government established (S.O. 1947, c.45, s.16) the "Unsatisfied Judgment Fund" under the *Highway Traffic Act*. Each person licensed to drive in Ontario was required to pay a stipulated amount into the Fund. Individuals who had been awarded damages arising out of a motor vehicle accident in Ontario by a court in Ontario, but who had been unable to collect the judgment, could, on proof of certain matters and subject to monetary limits, recover from the Fund. Individuals to whom loss had been occasioned by an unidentified driver could also recover in certain circumstances. In 1962, a new statutory regime was introduced and the "Motor Vehicle Accident Claims Fund" was created (*An Act respecting Claims for Damages Arising out of Motor Vehicle Accidents*, S.O. 1961-62, c.84). This Act introduced a new requirement, i.e., each owner of a motor vehicle was required to be able to produce evidence that either a vehicle was insured or the uninsured motor vehicle fee had been paid (section 3). It has subsequently been amended on several occasions, most recently on the introduction of compulsory insurance.

2.12 The *Insurance Act* was amended in 1970 (S.O. 1970, c.134) in several significant ways. The minimum licence requirements for subscribed and paid-up capital stock were increased dramatically (section 4). The Superintendent was given power to take control of the assets of an insurer where assets could not be accounted for satisfactorily (section 7). Two new parts, on investments and unfair and deceptive business practices, were added (section 17). In 1971, Schedule E was added to the Act (S.O. 1971, c.84, section 26), which established mandatory medical and rehabilitation benefits and accident benefits for those injured in an accident out of the use or operation of an automobile.

2.13 In 1972, the Act was amended to prohibit the granting of a licence to a corporation carrying on business as an insurance agent, broker or adjuster if the majority of its issued and outstanding shares were owned (beneficially or otherwise) by non-resident(s)(S.O. 1972, c.66, section 14).

2.14 Major revisions were made to the Act on the introduction of compulsory automobile insurance in 1979 and the self-regulation of brokers in 1980.

3.0 FEDERAL REGULATION: HISTORICAL HIGHLIGHTS

3.1 Although Parliament passed legislation governing insurance companies as early as 1868, disputes over federal constitutional authority, and specific federal legislation, were waged until 1931 (see Section 1.0 above). In 1932, Parliament passed two statutes which remain in force, subject to several major amendments, today: the *Canadian and British Insurance Companies Act, 1932* (S.C. 1932, c.46)(hereinafter "the C & B Act") and the *Foreign Insurance Companies Act, 1932* (S.C. 1932, c.47)(hereinafter "the Foreign Act").

3.2 Both Acts opened with recitals which were intended to underpin the competence of Parliament to legislate, and both Acts closed with a declaration that if any provision were held to be beyond the legislative competence of Parliament, it was to be treated as severable.

3.3 Generally, the C & B Act applied to companies incorporated by special Act of Parliament after May 4, 1910; to companies incorporated before that date but not licensed before that date; and to companies incorporated under the laws of the Dominion of Canada or the Province of Canada to carry on the business of insurance, which was defined as "the making of any contract of insurance, and includes any act or acts of inducement to enter into such a contract, and any act or acts relating to the performance thereof, or the rendering of any service in connection therewith" (subsection 2(d)). This definition has not been amended since 1932.

The C & B Act also governed every British company transacting business in Canada. "British company" was defined as "any corporation incorporated under the laws of the United Kingdom of Great Britain and Northern Ireland or any British Dominion or possession other than Canada or a province of Canada for the purpose of carrying on the business of insurance and includes 'association' as defined by this Act" (subsection 2(c)). It should be noted that "association" was defined to include Lloyd's (subsection 2(b)). In addition, a provincial company could register under the C & B Act and thereby certain sections of the C & B Act would apply to it (sections 149 and 154). A "provincial company" was defined as "a company incorporated under the laws of any province of Canada or of former province of British North America now forming part of Canada other than the late Province of Canada for the purpose of carrying on the business of insurance" (subsection 2(n)).

The Foreign Act applied to each company "incorporated under the laws of any foreign country for the purpose of carrying on the business of insurance, and includes 'association', 'exchange' and 'fraternal benefit society' as respectively defined by this Act" (subsection 2(g)).

Minor amendments have been made to these provisions but, on the whole, the scope of these Acts has remained unchanged to the present.

3.4 Both acts were amended during the 1930s, 1940s and 1950s; many amendments were made, in particular to the investment provisions.

3.5 In 1956, the minimum amount of statutory deposits was increased under both Acts (C & B Act: S.C. 1956, c.28; Foreign Act: S.C. 1956, c.30).

3.6 In 1957, significant amendments were made to the C & B Act. The requirement that a majority of directors be "ordinarily resident in Canada" was introduced (S.C. 1957-58, c.11, section 2). The directors of life insurance companies were given discretion to refuse to register transfers of stock to non-residents (broadly defined) unless the stock was already held by a non-resident (section 3). Finally, life insurance companies with capital stocks were authorized, with the permission of the Minister, to convert to mutual companies, and detailed provisions for such conversions were enacted (section 4).

3.7 In 1965, the non-resident ownership provisions pertaining to life insurance companies were tightened considerably. Directors were required to refuse transfers of stock to non-residents which would result in more than 25% of the total issued and outstanding stock being owned by non-residents, or more than 10% of such stock being owned by a single non-resident. A new life company, however, could be owned by non-residents so long as the shares were issued before the day on which the first general meeting of shareholders was held. (These provisions have never been extended to companies carrying on business other than life insurance.)

3.8 A requirement that each company subject to the C & B Act appoint an auditor for the purpose of completing an annual report to directors and the Superintendent was added in 1970 (S.C. 1969-70, c.14, section 24). In addition, the Superintendent and the Minister were given certain powers to intervene where the assets, in the case of a life company, could not be accounted for satisfactorily (subsection 28(1)) or where, in the case of a general company, the assets fell below the statutory standard of solvency (section 34).

Minimum unimpaired capital stock and surplus requirements for registration purposes were introduced (subsection 16(2)) as follows:

life company:	paid-up capital stock	— at least $1,000,000
	surplus	— at least $ 500,000
	total	— at least $2,000,000
general company:	paid-up capital stock	— at least $ 750,000
	surplus	— at least $ 250,000
	total	— at least $1,500,000

3.9 In 1977, companies under the C & B Act were given additional powers to carry on other business (S.C. 1976-77, c.39, section 2):

> 4.6(1) A company may, with the consent of the Minister, carry on any business that is reasonably ancillary to the business of insurance transacted by the company.

Also, new solvency tests for minimum assets to be maintained by general companies were put in place (subsection 17(1)).

4.0 ELEMENTS OF CONTROL: *INSURANCE ACT* (ONTARIO) AND *CANADIAN AND BRITISH INSURANCE COMPANIES ACT*[3] (CANADA)

4.1 Incorporation

4.1.1 **Ontario**

Joint-stock insurance companies, mutual insurance corporations, cash-mutual insurance companies, fraternal societies and mutual benefit societies may be incorporated under the provisions of the *Corporations Act*, R.S.O. 1980, c.95, Part V (Insurance Corporations). It should be noted that the definitions included in section 1 of the *Insurance Act* also apply to Part V of the *Corporations Act*. Insurance means (subsection 1.3.0) "the undertaking by one person to indemnify another person against loss or liability for loss in respect of a certain risk or peril to which the object of the insurance may be exposed, or to pay a sum of money or other thing of value upon the happening of a certain event and includes life insurance." Thus the *objects* of an insurance company will be limited to insurance (although it will have the incidental powers set out in section 23 of the *Corporations Act*).

The Lieutenant Governor may, in his discretion, by letters patent, issue a charter to the prescribed number of qualified persons (subsection 4(1)). The Act does not contain any standards of integrity, experience or fitness for the incorporators.

The *Corporations Act* also governs certain features of corporate structure and governance. For instance, directors must hold qualifying shares in a joint-stock insurance company (section 209). The shareholders are required to appoint auditors (sections 94 and 95).

4.1.2 **Federal**

Although, in the early years, federal companies were incorporated by special Act, they are now incorporated by letters patent issued by the Minister of Consumer and Corporate Affairs with the concurrence of the Minister of Finance (subsection 4.1(1)). Provincially-incorporated companies also may apply for letters patent through a trans-jurisdictional incorporation procedure (section 4.5). The effect of the letters patent is to create a corporate body "for the purpose of carrying on the business of insurance" (which is defined above in section 3.3). A federal company since 1977 has had additional powers as follows (emphasis added):

> 4.6 (1) A company may, with the consent of the Minister, carry on any business that is *reasonably ancillary* to the business of insurance transacted by the company.
>
> (2) A company may provide *administrative, advisory and management services* to any corporation *where* the company holds shares of that corporation acquired under section 64 or 65.

A federal insurance company therefore is limited in its objects. The C & B Act does not delineate incidental powers, although it does provide as follows:

> 4.1 (2) A company incorporated by letters patent pursuant to subsection (1) is invested with all the powers, privileges and immunities conferred by this Act, and applicable thereto, and is subject to all the limitations, liabilities and requirements set forth in this Act, and applicable thereto, and has the like capacity of a company incorporated in the manner described in section 4 [by special act].

The C & B Act governs certain features of corporate structure and governance. Directors must hold qualifying shares in a joint-stock company (subsection 6(3)). Agents cannot be appointed directors, and the number of paid officers who can sit on the board is limited to two in addition to the President and Secretary (subsection 6(10)). Shareholders are required to appoint auditors (section 78.1 and section 3.8 above). As above, the Act does not contain any standard of integrity, experience or fitness for the incorporators.

4.2 Licensing

4.2.1 **Ontario**

The following entities are required to be licensed in Ontario:

- an insurer undertaking a contract of insurance deemed to be made in Ontario (subsection 20(2));

an insurer carrying on business in Ontario (subsection 20(3));
- underwriters' agencies (section 91); and
- reciprocal or inter-insurance exchanges, which, however, are distinct from insurers (sections 332 and 335).

It is clear that a licensed insurer may enter into a contract with an unlicensed reinsurer so long as the reinsurer can be said to be "transacting business out of Ontario" (section 22). The result is that a reinsurer need not be licensed in Ontario merely as a result of contracting with an Ontario-licensed company. The key question is the *situs* of the contract.

Although section 9 provides that it is within the discretion of the Superintendent to decide whether a licence should be granted, subsection 23(1) states that the Minister issues the licence. Subsection 23(2) establishes the scope of the licence as follows:

> 23. (2) A licence issued under this Act authorizes the insurer named therein to exercise in Ontario all rights and powers reasonably incidental to the carrying on of the business of insurance named therein that are not inconsistent with this Act or with its Act or instrument of incorporation or organization.

Most types of insurers applying for a licence must make a deposit of approved securities with the Minister, although the amount of such deposit is in no case greater than $50,000 (subsection 46(1)). In addition, those licensed after January 1, 1971, must meet minimum capital or surplus requirements (section 28) which may be set at the levels determined appropriate by the Minister. Bill 108 *(An Act to amend the Insurance Act)* was introduced on February 12, 1986. It contains amendments to section 28 which will increase the minimum aggregate amount for a non-life insurance company to $3,000,000, with a transitional phase to continue until 1991 to allow all companies to move from the current minimum of $1,000,000. There is provision for the Lieutenant Governor in Council to exempt an insurer from these requirements "if the insurer is offering its services only within Ontario or if the insurer is offering a specialized or limited service that in the opinion of the Lieutenant Governor in Council does not require the support of higher capital requirements".

An insurer who has complied with the Act and the *Corporations Act* is *entitled* to a licence, although the licence may be subject to limitations and conditions (subsection 24(4) and subsection 25(4)). If a licence is varied at any time other than upon issuance or renewal, the Minister must give the insurer notice of such change and a reasonable opportunity to respond.

4.2.2 **Federal**

If a company does not hold a certificate of registry from the Minister, it is prohibited from transacting the "business of insurance" except as may be required for the protection of the company's policyholders (subsection 52(1)). Marine insurers are exempted from the registration requirement (subsection 101(2)). A certificate of registry may contain limitations or conditions (subsection 55(4)) and it may be varied during its term if certain procedural safeguards are met (subsection 55(5)). The Superintendent is under a statutory duty to make a report to the Minister, with respect to an insurer's compliance with the Act and its financial condition, before the granting or renewal of any certificate of registry.

4.3 Share Ownership — Upstream

4.3.1 **Ontario**

Neither the *Insurance Act* nor the *Corporations Act* limits who may be a shareholder. The Superintendent must be given 30 days' notice of any transfer of shares equal to 10% or more of an insurers' issued and outstanding shares and of any transfer which would result in one person owning, directly or indirectly, a majority of the shares of the insurer (section 79). No statutory authority is given to intervene in such transfers.

4.3.2 **Federal**

Notice of any transfer of 10% or more of the total outstanding shares of a company, or of 10% or less if the transfer would result in one person owning, directly or indirectly, a majority of the shares, must be given to the Superintendent 30 days before the transfer (section 10.1). The Superintendent does not have any statutory power to intervene in the transfer.

The C & B Act limits non-resident ownership of life insurance companies (see section 3.7 above) but it does not contain similar provisions with respect to companies transacting other than life insurance business.

4.4 Investments Generally

4.4.1 **Ontario**

The types of investments which are permissible for insurers incorporated or organized under the laws of Ontario are governed by Part XVII of the Act. The Superintendent may order appraisals of assets held by an insurer if the Superintendent has reason to believe that the values shown in the annual statement are inflated and the Superintendent may change such values and report such changes in his annual report (subsections 17(4) to 17(6)).

4.4.2 **Federal**

A company subject to the C & B Act may invest only in such securities as are prescribed by the Act (section 63). The Superintendent has similar powers with respect to appraisals of real estate (section 75) as under the Ontario Act. The federal Department has proposed to amend section 75 to give the Superintendent greater remedial powers. Instead of being limited to stating the changed value in his annual report, he will be given authority to use the changed value for purposes of the solvency test and all other provisions of the legislation. Such powers will extend to the real estate holdings of subsidiaries.

4.5 Investments — Downstream Subsidiaries

4.5.1 **Ontario**

Generally, an insurer may invest in common shares of a corporation only if those shares meet one of the earnings tests specified (subsection 388(1)). A life insurance company, however, has an expanded authority to invest in the fully paid shares of certain other corporations (subsection 388(8)). Insurers licensed to transact business other than life insurance do not have such expanded powers.

4.5.2 **Federal**

Generally, an insurer may invest only in common shares which meet specified earnings tests (paragraph 63(1)(m)) subject to a maximum limit of 30% of the common shares of any corporation. These limits may be exceeded, however, by a non-life insurance company as follows:

> 64. Notwithstanding anything in subsection 63(1), a company, other than a company registered to transact the business of life insurance, may invest its funds in the fully paid shares of
>
> (a) any other corporation transacting the business of insurance, and
> (b) with the prior approval of the Minister, any corporation incorporated to carry on any other business that is reasonably ancillary to the business of

insurance transacted by the company,

subject to such terms and conditions as may be prescribed by the regulations.

Life insurance companies are also given expanded investment powers in subsidiaries in section 65.

4.6 Minimum Financial Requirements

4.6.1 **Ontario**

All insurers must have under their control assets in Canada at least equal to their total liabilities to policyholders in Canada (subsection 392(2)). Although the Act provides for the calculations of life insurance reserves, it is otherwise silent on how liabilities and assets are to be calculated. Woods, Gordon & Co. prepared a report for the Select Committee on Company Law in January 1978 (Report XI: Solvency and Liquidity Rules). It detailed the Department's in-house rules. Notwithstanding the recommendation of the Committee as noted in that Report, rules for this purpose have not been enacted by statute.

4.6.2 **Federal**

The C & B Act provides, in subsection 103(1), detailed rules for determining the minimum amount of permissible assets required to be maintained by a company, which must be maintained in Canada. These assets may be reduced where a liability has been reinsured with a licensed reinsurer (subsections 103(1.15) to 103(1.19)). Amendments have been proposed to this section. In addition, it is anticipated that new reserves will be required (under subsection 71(4)) for amounts due from agents and affiliated companies.

The payment of dividends is prohibited where a company's capital is impaired, the assets are less than minimum or the payment of the dividend would reduce the assets below the minimum amount (subsection 103(3)). Further, if dividend payments can be made, the amount is limited as provided in section 105. The Department has proposed an amendment to section 105 that would lower the ceiling on allowable dividends if the statutory capital and surplus of a company is less than $5,000,000. The intended result is that more profit will be retained in smaller companies and surplus will grow.

4.7 Accountability Mechanisms

4.7.1 **Ontario**

Historically, the major mechanisms on which the Superintendent has relied have been: (1) the requirement for an insurer to file an annual statement in the form prescribed by the Superintendent not later than the last day of February (subsection 8(1)), which statement must also be *verified* in the manner prescribed; and (2) the requirement that the Superintendent attend upon each insurer annually to conduct an examination (section 15).

Generally, the Superintendent and the Minister have been given remedial powers which can be invoked in certain circumstances. The Minister may suspend or revoke a licence where:

- an insurer has failed to pay an undisputed claim (section 36);
- an insurer has failed to keep its deposit unimpaired (section 37);
- upon completing certain procedural requirements (including giving the insurer a reasonable time to be heard), the assets of an insurer are insufficient or it has failed to comply with the Act or its constating documents (section 30).

Further, where an insurer cannot satisfactorily account for its assets, the Superintendent may take control of the assets of an insurer (section 39). The Superintendent must report to the Minister (whether or not he has taken control of the assets of an insurer) when the former is "of the opinion that the assets. . . are not sufficient to justify its continuance in business or to provide for its obligations under its policies" and thereafter procedures are prescribed for requiring certain remedial measures to be taken by the insurer, taking control of the assets of the insurer if the remedial measures are not satisfactory, rehabilitation of the insurer or winding-up of the insurer (sections 40-41).

The Superintendent has access to the books of an insurer (section 13) and an insurer must respond to inquiries (section 14). The Superintendent may require the filing of certain statistical returns on experience in general lines (section 80). The Superintendent may also require the filing of insurance policies from time to time (section 94).

The Act contains certain general controls on the contracts of an insurer, the most important being:

> 103. (1) No insurer shall make a contract of insurance inconsistent with this Act. . . .
>
> 94. (2) The Superintendent shall report to the Minister any case where an insurer issues a policy or uses an application that, in the opinion of the Superintendent, is unfair, fraudulent or not in the public interest, and after hearing the insurer the Minister may, if he concurs in the report, order the Superintendent to prohibit the insurer from issuing or using such forms of policy or application.

Further, Part XVIII of the Act prohibits certain unfair and deceptive practices (section 394) and gives the Superintendent the power to issue a cease and desist order (section 395).

4.7.2 **Federal**

The C & B Act requires that an annual statement be filed in provisions similar to those of the Ontario Act (section 70(1)). While a life insurance company must report changes in investments and loans on a half-yearly basis, a non-life insurance company is not subject to the same requirement. It is proposed, however, to amend the C & B Act to require any company to file interim financial statements in such detail and with such frequency as required by the Superintendent.

Currently, the C & B Act provides that the annual statement must include a report by a valuation actuary with respect to any reserve shown for non-cancellable accident and sickness policies and for claims under accident and sickness policies payable in instalments (subsection 102(4)). It is proposed to amend this provision to require that each company submit a special report signed by an actuary, stating that in the actuary's opinion, the provision for outstanding claims represents a fair and reasonable estimate of the amounts that will be required, together with the amounts receivable from reinsurers, to settle the claims in full. The proposed amendment therefore is a significant change and it is anticipated that transitional provisions will be put in place.

The Superintendent is required to conduct an examination of each insurer annually (subsection 72(d)).

The Superintendent is required to report to the Minister in certain situations which signal that an insurer may be in difficulty (subsection 103.2(1)). The Minister is authorized to take certain action after giving the insurer a reasonable time to be heard. These actions are:

> 103.2(2). . .
> (a) he may make the company's certificate of registry subject to such limitations or conditions as he considers appropriate;
> (b) he may prescribe a time within which the company shall make good any deficiency or inadequacy of assets. . .; and
> (c) he may direct the Superintendent to take control of the company's assets.

The C & B Act prescribes the procedures to be followed when control of a company's assets is taken and the result may be either rehabilitation or winding-up of the insurer (section 103.3).

The Superintendent has access to the books of an insurer during an inspection (subsection 73(1)). Insurers are under a statutory duty to respond promptly to inquiries from the Superintendent (section 76).

5.0 ELEMENTS OF CONTROL: *CANADIAN AND BRITISH INSURANCE COMPANIES ACT*[4] AND *FOREIGN INSURANCE COMPANIES ACT* (CANADA)

5.1 Licensing

Both British and foreign companies are prohibited from transacting the "business of insurance" in Canada unless they hold a certificate of registry (section 122 and section 4). Conditions or limitations may be added to a certificate by the Minister on renewal; a change may be made at any other time subject to the obligation of the Minister to give the insurer an opportunity to be heard (subsection 126(4) and subsection 19(4)).

5.2 Minimum Financial Requirements

Canadian branches are required to maintain minimum assets in Canada calculated on the same basis as Canadian-incorporated companies (section 128 and section 14). It is proposed to increase these requirements as for Canadian companies. These assets may be vested with a trust company (section 129 and section 20) or they may be placed on deposit with the Receiver General. Permissible securities are prescribed for both categories of assets. (It should be noted, however, that British and foreign companies may make investments in Canada other than those minimum assets required and such investments are essentially unregulated.)

5.3 Accountability Mechanisms

In addition to the requirement to file annual statements with respect to its Canadian branch (section 130 and section 21), each registered company is also required to file its general business statements (that is, the statement reporting its worldwide business which is required by its jurisdiction of incorporation (section 131 and section 22). It is proposed that both British and foreign branches be required to file interim financial statements when requested by the Superintendent, and to add certification by a valuation actuary.

The Chief Agent for Canada of British and foreign branches is under a statutory obligation to keep certain records which are available to the Superintendent (sections 132 and 24). The Superintendent is required to conduct an annual examination of the branch, and the Minister may also order a head office examination (section 136 and section 31).

The Minister may withdraw the certificate of a British company and, if it is not renewed within 30 days, the branch is deemed to be insolvent and subject to be wound up (section 145). This summary procedure is not available in the case of foreign branches.

Where the assets of a branch are insufficient for the protection of policyholders in Canada, the Superintendent must so report to the Minister, who has several remedial powers which can be used on notice to the branch, including taking control of the assets of the branch (section 146 and section 51).

6.0 RECENT STUDIES ON THE REGULATION OF CANADIAN FINANCIAL INSTITUTIONS

6.1 A series of reports published in the last year have made a variety of recommendations with respect to the regulation of financial institutions. The three to be discussed herein are:

> Department of Finance — Canada: The Regulation of Canadian Financial Institutions: Proposals for Discussion (April, 1985) (hereinafter the "Green Paper");
>
> Report of the Standing Committee on Finance, Trade and Economic Affairs: Canadian Financial Institutions (November, 1985) (hereinafter the "Blenkarn Report"); and
>
> Ontario Task Force on Financial Institutions (December, 1985) (hereinafter the "Dupré Report").

6.2 The impetus for these studies arose from two sources. On the one hand, the types of financial intermediaries often referred to as the "four pillars" of our financial markets (banks, trust and loan companies, insurance companies and securities dealers) were urging that the traditional approach of separation of powers of financial intermediaries be altered to allow such intermediaries to compete directly, thereby fueling growth. On the other hand, intermediaries were failing at a startling rate, with the result that public decision-makers were pressed to increase the level of control by designing and implementing mechanisms to protect consumers and ensure market stability.

6.3 It should be noted that life insurers are considered to constitute the insurance "pillar", not property-casualty insurers. Life insurers play a much greater intermediation function than do property-casualty insurers. Although for policy analysis purposes the two types of insurers were treated as being similar, the validity of that premise is questionable.

6.4 None of the reports recommend that the separation of powers model be changed. Their principal focus was on how the separate entities could be arranged so as to accommodate the aims of both the regulated and regulators. The Green Paper and the Dupré Report opted for the consolidation of ownership interests in separate entities in an upstream holding company and approved of the concept of an additional type of bank which could be closely held:

> A federally incorporated financial holding company would be required if a federally regulated financial institution were among a group of two or more financial institutions operating under different legislation that shared a common 'substantial shareholder'; that is, an investor or group of associated investors that held more than 10% of the voting shares of each of the companies involved. (Green Paper, pp. 31-32.)
>
> It should be a principle of public policy that ownership links between financial institutions operating under different legislation should be permitted only through a financial holding company. (Dupré Report, p. 12.)

The Blenkarn Report rejected the structural rigidity of this approach and recommended that:

> non-bank financial institutions be allowed to diversify flexibly through upstream holding companies and affiliated institutions, downstream holding companies and subsidiaries, together with some limited expansion of in-house rules [particularly with respect to commercial lending] and networking arrangements. (Blenkarn Report, p. 15.)

6.5 It follows from the choice to maintain separate corporate identities by function that some form of linkage between the entities must be sanctioned. All these reports support networking (excluding tied selling) amongst entities (whether affiliated or not).

In the view of the Dupré Report, however, networking arrangements should be regulated through disclosure requirements:

> When two or more financial institutions propose to enter into a contractual arrangement in regard to the sale of financial products or services, such an arrangement should require the approval of whichever regulators may be responsible for the supervision of the respective contracting parties. Before approving any arrangement, the regulators should be satisfied that the proposed arrangement will not result in practices that are directly or indirectly akin to tied selling, that the contracting parties possess the necessary expertise to offer the services that are the subject of the arrangement, and that they have procedures in place to guard their customers against any adverse consequences as a result of any conflicts of interest arising from the arrangement. In assessing the desirability of particular networking arrangements, the regulators should take favourable note of arrangements designed to enhance consumer services in small communities. (Dupré Report, p. 15.)

The Dupré Report noted that 84% of insurance in Ontario is routed through brokers (p. 73) and recommended that the role of independent agents and brokers be supported:

> In particular, the Government of Ontario should take special care that its own regulatory and policy initiatives taken with regard to financial institutions will preserve a climate that is favourable to the role played by independent agents and brokers in enhancing competition and quality of service. . . . (Dupré Report, p. 74.)

6.6 The reports did not include any projections of the effects which such structural changes are likely to have on the way the insurance industry does its business and on its profitability.

6.7 All three reports stated that the primary concern of both public decision-makers and consumers with respect to financial intermediaries was solvency. The Green Paper concluded:

> One of the questions raised by recent developments in Canada's financial system is the following: has the development of links among different types of institutions had a bearing on the risk of insolvency? . . . Given the diversity of financial system structures currently in place around the world, there does not appear to be any clear connection between the stability of a financial system and any particular structure. (Green Paper, p. 15.)

6.8 Although the reports contain some commentary on the reasons for the failures of various financial institutions, the analysis is not general and most of the examples are drawn from banking and trust company sectors. A comment on the circumstances of failed property-casualty insurers was included in the Blenkarn Report:

> A few factors have played a major contribution in the insolvencies that have occurred: inadequate capitalization, failure to maintain sufficient premiums, understatement of liabilities and inadequate reinsurance protection. (Blenkarn Report, p. 102.)

It should be noted that these reasons differ significantly from the circumstances of failed trust companies and banks.

6.9 Both the Blenkarn Report and the Dupré Report make recommendations in response to current inadequacies in both regulatory powers and statutory approaches to corporate government. A number of these recommendations have been included in the proposed federal amendments and Bill 108 (Ontario), in particular:

FEDERAL—BLENKARN REPORT

- proposed amendment to subsection 103(1) with respect to minimum continuing capital and surplus requirements

  (NOTE: "On an overall basis, the inclusion of this test would not have a major impact on the current solvency margin of the property and casualty industry. It would help to correct certain technical flaws . . . and would affect a few companies which today are able to operate with a very small capital base in relation to their operations and still pass the present tests". (Blenkarn Report, p. 102.))
- proposed reinsurance regulations (although the Superintendent's proposals go well beyond the single recommendation in the Blenkarn Report that premiums ceded to a non-registered insurer cannot exceed those ceded to a registered insurer; p. 105)
- actuarial reports in respect of claims and unearned premium reserves
- cease and desist orders

ONTARIO—BILL 108

- compensation associations (property-casualty only)(p. 10)
- higher initial capitalization (p. 23)

In fact, however, the majority of the recommendations in both reports have not been included in the proposed legislation. Some of the recommendations hinge upon decisions about the purposes and design of the regulatory structure, while others require a major overhaul of corporate governance.

7.0 AGENTS AND BROKERS

7.1 Agents

It will be recalled that insurance agents in Ontario have been subject to a statutory requirement to be licensed since 1914. "Agent" is defined in the *Insurance Act* (subsection 1.15) and does not include *(inter alia)* a member of Registered Insurance Brokers of Ontario. Individuals, partnerships or corporations may be licensed in three categories: life insurance (which can be combined with accident, or accident and sickness insurance), accident and sickness insurance, and all other classes of insurance. A person may hold two licences in respect of life insurance and all other classes of insurance. Agents who are employees of insurers have not, to date, been required to hold a licence.

A person is not entitled to a licence as a matter of right but must be: (1) appointed by an insurer; and (2) a suitable person who intends to hold himself out publicly as an agent and carry on business in good faith. An agent can be appointed by only one company (except in the case of an agent licensed for life *and* accident insurance, or life *and* accident and sickness insurance. (A life insurance agent may, with the written consent of the appointing company, procure insurance from another insurer which the agent has not been able to negotiate with the appointing company.)

The majority of the issued and outstanding shares of corporations carrying on business as agents must be owned by residents of Canada unless the agent was licensed on or before April 27, 1972. A corporation which has been so "grandfathered" is not entitled to continue to hold its licence if it combines its business with that of another licensed agent.

A licence may be revoked by the Superintendent only for certain stated reasons (including incompetency or trustworthiness) after granting a hearing to the agent.

7.2 Brokers

Since 1980, brokers have been regulated persuant to the *Registered Insurance Brokers Act* (R.S.O. 1970, c.444). The statutory definition of "broker" is broader than the common law definition and includes (subject to certain specific exemptions, e.g., an employee of an insurer) any person who provides any service directly to the public with respect to contracts of insurance other than life insurance. Brokers are not required to be licensed by the Superintendent; instead, they must be registered by the Registered Insurance Brokers of Ontario, a Corporation continued under and governed by the Act. The principal provisions governing qualification are contained in regulations made by the Lieutenant Governor in Council under the Act.

NOTES

[1] The audit requirement was removed and replaced by a provision authorizing the Minister to nominate a person to conduct one from time to time. R.S.O. 1927, c.222, s-s 69(2).

[2] Repealed S.O. 1926, c.49, section 5.

[3] Canadian companies only.

[4] British companies only.

APPENDIX 10

PROFESSIONAL LIABILITY INSURANCE

A paper delivered April 22, 1986, to the Slater Task Force on Liability Insurance by W. Donald Lilly, Q.C., a member of the Insurance Advisory Committee.

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INTRODUCTION

The Task Force is to cover cost and capacity problems, possible approaches to resolving problems and proposals to create on a long-term basis increased market stability, policyholder protection and a climate of economic opportunity for insurance companies in Ontario.

When completed, the Task Force Report will be given wide circulation and there will be full opportunity for public response.

This paper is to deal specifically with professional liability insurance. Since the Task Force is dealing with the larger questions on a broad basis this paper is limited as follows:

(a) It is based on interviews, submissions, discussions with members of the Task Force and Advisory Committee, specific information from statistical data where available and general research, but in the limited time and with the limited financial information available, it can be no more than general impressions. Public response to the paper will no doubt refine the information.

(b) While it appears that premiums have risen dramatically and limits have contracted, we make no attempt to explain why, nor do we intend to convey any criticism or approval. The workings of the insurance industry are covered by Dr. Slater's report, which provides recommendations to strengthen and enlarge the insurance industry role in the protection of professionals.

(c) The benefits or problems associated with self-insurance are covered by Dr. Slater's report. We refer to self-insurance here because it has become one of the initiatives taken by some associations.

(d) Details of recommendations are left to be worked out in the future. They are conceptual only. We hope they provide the way to some solutions.

PART I: OVERVIEW

A. THE TRADITIONAL INSURANCE MARKET

1. Errors and omissions insurance at present premium levels for all professionals across Canada would require premium capacity in excess of $100,000,000.
2. Few of the major insurers write this kind of business. Many of the specialty insurers have ceased doing so. Only the Simcoe & Erie pool remains as a substantial insurer in this class. The other remaining insurance facilities have little impact on capacity. This is not likely to change for several years because reinsurance is almost unattainable.
3. Most of the reinsurance comes from Lloyd's. It regards Ontario in the same light as it does the United States, where in professional liability it has had disastrous results. Lloyd's are not likely to reenter the professional liability reinsurance field in North America for a very long time. The American reinsurers will likely serve the enormous needs of the American market in preference to the Canadian market.
4. Professionals are faced, therefore, with long-term restricted availability, and the present insurers, including the Simcoe & Erie pool, cannot be expected to provide coverage to all professionals across Canada at current limits and deductible levels. Professionals relying on the traditional insurance market must get used to lower limits, higher deductibles and, for a certain percentage of the professions, no insurance at all.

B. SELF-INSURANCE

5. Some professionals are responding by setting up self-insurance facilities. Since this will provide extra capacity, they should be encouraged. Any legislation necessary to prevent contravention of the *Insurance Act* should be passed and implemented on an urgent basis.
6. This can be done if the government sponsors excess and reinsurance facilities which otherwise will be unavailable to them. The government should be prepared to do so if it

insists (as in the case of architects and engineers) on insurance as a mandatory or compulsory pre-condition to a licence to practice. The reinsurance facility on a commercial basis could be on the condition that losses would be paid back by the professionals over a specified time, say a 10-year period.

7. The very large engineering and accounting firms are involved in a variety of activities worldwide, including activities in the United States. This has resulted in severe reinsurance problems. Because their potential exposure is enormous, they require at least $100,000,000 limits. The reinsurance market is not able to provide limits of more than about $25,000,000.

   They are interested in setting up their own self-insurance facility and can back it with their own assets to a very high primary layer. But they need catastrophic loss protection to protect them from liability disaster. If we believe in an international presence, the government should sponsor a reinsurance pool at the upper limits and provide tax benefits to allow a quick reserve build-up to meet any catastrophic loss that might occur.
8. While the judicial system is not at the root of the insurance crisis, there are a number of specific legal problems which, if solved, may help to control unfair risk exposure. They include pre-judgment interest, collateral benefits, limitation periods, *Family Law Reform Act* awards, joint and concurrent liability, OHIP subrogation and other like matters. They are discussed separately under Part III.

PART II: THE CURRENT INSURANCE SITUATION

A. ARCHITECTS & ENGINEERS

The Architects and Engineers are represented by the Ontario Association of Architects, the Consulting Engineers of Ontario and the Association of Professional Engineers of Ontario.

Each of these associations has association-sponsored errors and omissions policies underwritten by the Simcoe & Erie pool and managed by National Insurance Managers, Inc. (NIM, formerly National Program Administrator).

Simcoe & Erie is an Ontario-licensed insurer with considerable experience in the professional liability field. Its capital base has recently been augmented by outside investors. As well, it manages a pool of money from a number of other insurers interested in insuring professionals. Its combined capital base, experience and interest in the professional liability field will provide a very significant source of errors and omissions insurance for professionals across Canada for the future.

NIM is a management service not normally found in an insurance program. It is owned jointly by Simcoe and Erie Investors Limited, Simcoe & Erie General Insurance Company and ENCON Insurance Managers Inc. It performs some of the underwriting functions of Simcoe & Erie and provides risk management seminars to the professions.

Other insurers have provided competing insurance policies until recently. While none of them were endorsed by the associations, they provided important capacity and premium competition. Of particular note were L. W. Biegler and Coronation, which provided about 20% of the capacity. Both of these companies no longer provide this insurance.

Others, such as Markel and INAPRO, withdrew over the last two years. Kansa continues to write a small volume of selected risks, as does American Home, but there is only one remaining underwriter which can significantly serve the needs of architects and engineers across Canada and that is Simcoe & Erie.

While several reasons are given for the withdrawal of the other insurers, it always relates back to the one recurring problem — an inability to put together a reinsurance program.

1. Availability and Premiums

There are no accurate statistics as yet available. But reasonably accurate conclusions can be made from the information available.

At current premium levels, over $100,000,000 of premium is required to cover all professionals insured by the traditional market (i.e., architects, engineers, accountants, brokers, surveyors, nurses, etc.) across Canada. It is highly unlikely that the Simcoe & Erie program would dedicate that much investment to professional liability insurance.

Clearly, other facilities must be established. Indeed, there is presently a great deal of activity by the large brokerage houses to put together new facilities, but they are all met by the same problem. There is no suitable reinsurance available to them.

This problem is not a temporary cycle. Lloyd's has historically provided most of the reinsurance in this field. It looks on Canada (and Ontario in particular) as merely an extension of the United States, and there, the professional liability insurers have experienced disastrous results. Last year, 33% of architects and engineers in California were left to practice without insurance, and this year Lloyd's has simply withdrawn from North America. The underwriters we talked to at Lloyd's say they have no plans to return in the foreseeable future. They have lots of capital but they can put it to much better use elsewhere.

The American reinsurers likewise regard Ontario as the "California of the North". While American Reinsurance is involved on the Simcoe & Erie program, it is unlikely that other American reinsurers can be persuaded to invest in new professional liability facilities.

Canadian Reinsurance, a subsidiary of Swiss Reinsurance, was for years the major reinsurer on the Simcoe & Erie program. It withdrew from that facility over a year ago and is not likely to reenter the market for a new facility.

There is also the concern about premiums. It is the Associations' overall impression that for those insured in the Simcoe & Erie program, premiums increased this year on average about 60%. For those moving from the other facilities, the premium increases were between 200% and 300%, with some quote increases as high as 1000%.

The most accurate statistical data comes from a recent RIMS survey for the United States and Canada which indicates the following:

RIMS SURVEY
USA & CANADA

Availability:	
Easy to Purchase	15%
Somewhat Difficult	21%
Much Difficulty	26%
Unavailable	11%
Not Renewed	9%
Cancelled	4%
Not Purchased	31%
Change in Premiums:	
Decrease	4%
No Change	10%
Increase 1-10%	8%
Increase 11-50%	19%
Increase 51-100%	18%
Increase 101-200%	12%
Increase 201-500%	18%
Increase over 500%	11%

Additional information has been provided by association surveys as follows:

(i) An OAA 3-year survey indicates total gross fees of all practicing architectural firms is $275,000,000. Premium rates in 1984, depending on the size and type of firm and coverage provided, varied from $1.70 to $2.90 per $100 of gross fee income.

In 1985–86 rates on average appeared to be in the $4.75 to $8.25 range, with the lower end providing only minimal coverage with a much larger ($50,000) deductible.

Because of their inability to pay the high premium cost, 40% of those firms having a total staff of three or less (these represent 46% of all practicing firms) are currently uninsured.

In total, 35% of all practicing architects are uninsured.

(ii) An APEO July 1985 survey indicates that 16% of its 45,000-member association cannot buy errors and omissions insurance at any price. An additional 15% (1,500 engineers) have not purchased it because the cost is so high that the firms simply cannot afford it and remain financially viable.

It is virtually impossible to purchase limits of over $1,000,000. Specific insurance policies for specified projects in excess of a $1,000,000 limit are available but at exorbitant cost. Recently, one firm required $5,000,000 limits for a relatively simple project. The cost of this insurance was $8,000, while the related engineering fee was $50,000.

Premium increases ranging from 60% to 500% and more were reported. Premiums are now running generally from 1.5% to over 6% of gross billings with coverage shrinking and deductibles increasing. A few years ago by comparison, premiums ranged from .5 to 1.5%.

The very large engineering firms which historically required $25,000,000 limits and considerably higher for some projects now find that $10,000,000 is the maximum available, with only $5,000,000 limits for projects in the United States. One engineering firm did get $20,000,000 for a project but this does not seem to be representative.

For their reduced limits these firms are paying overall premium increases of 70% and more with premiums exceeding $1,000,000.

They also have severe comprehensive general liability coverage problems for their products sold in the United States. One such firm had $100,000,000 limits for a subsidiary selling products in the United States. This was reduced to $1,000,000 limits costing more in premium than it paid for the higher limit.

Clearly, long-term solutions must be found.

Capacity must be increased and reinsurance at affordable premium levels must be available.

Some professional associations are responding by trying to set up self-insurance facilities. They believe that they are in an ideal position to self insure. They are disciplined and organized and they are capable of sophisticated educational and risk management programs to control losses. Their self-insurance retention would demonstrate to reinsurers a meaningful and direct interest in their well-being. They could keep the kind of statistics which reinsurers want at renewal.

We understand that some layers of reinsurers are reasonably receptive to self-insured programs provided that the associations come with rational risk analysis and rate studies. But some layers may be unavailable or available only at unacceptably high premium levels.

The Ontario government can solve that problem by providing to the self-insured professionals reinsurance on a commercial basis. In the event of loss, the profession should reimburse the government over some time at an agreed interest rate. Such participation is justified on the following grounds:

(a) At present, architects and engineers will be required on a mandatory or compulsory basis to obtain insurance as a precondition to a licence to practice. If the government insists on this precondition, it has the duty to ensure that the insurance is available at acceptable premium levels;

(b) Coverage provided protects the public at large in the event that some members of the community incur damage;

(c) The government sustains no financial loss if the profession reimburses it over time for losses paid out plus interest;

(d) The international insurance crisis is too large for the professionals to solve by traditional methods. The situation justifies government intervention.

2. Compulsory/Mandatory Insurance

In the late 1970's and early 1980's, the Province of Ontario undertook a detailed review of legislation governing engineers, architects, lawyers and accountants. A major thrust of this review was protection of the public. After study, negotiation and compromise, Bill 123 was introduced to require insurance on a compulsory basis. It has not as yet been implemented, largely because of the difficulty in obtaining insurance.

The engineers in particular strongly urge that the notion of compulsory insurance be abandoned. They argue that:

(a) In the case of the Association of Professional Engineers of Ontario (APEO) about three-quarters of the member engineers are working as employees for government or manufacturers who have existing insurance protection. Therefore only about 10,000 members are truly consulting engineers who do not have this already existing protection.

(b) These remaining 10,000 member consulting engineers do not work directly for the public. They are engaged by business clients who themselves have insurance and assets to respond to claims from the public.

(c) The consulting engineers perform a wide variety of comparatively unrelated functions (i.e., design and supervision of construction, managing existing installations, research in a great variety of subjects, testing new technologies, etc.) which make it difficult to develop common initiatives.

(d) Most of the consulting engineers are employees who have less control and authority to obtain insurance in the name of the business they work for. They say that it is unfair to deny them a licence to practice on the grounds that they have no insurance, when they as employees have virtually no control over obtaining it.

(e) The right to practice should not be determined by whether they can get insurance. The insurer who is asked to issue the certificate may base its decision on matters that are not at all related to the competence of the engineer who is applying. The right to review this decision is difficult.

(f) A certain proportion of the profession never could, cannot now, and never will be able to purchase errors and omissions insurance because of the nature of their activities. A June 1985 survey conducted by APEO indicates that 16% of its 45,000-member association fall into this category.

(g) At the present time, insurance at affordable rates for many engineers is not available. The June 1985 survey by APEO indicates that 15% (380 firms), in addition to the 16% referred to in subparagraph (f), do not carry errors and omissions insurance because of costs which they say are so high that they threaten the financial viability of the firms.

(h) Implementation of compulsory insurance would have a devastating effect on employment. The 15% of members who do not carry insurance because of cost alone represent 380 firms employing 1,500 engineers and 3,500 other employees. APEO estimates that the requirement could threaten over 37,000 jobs.

We cannot, of course, ignore the extensive study of the problem already completed, and the reasons for introducing Bill 123. Because attention has been directed to strictly insurance questions in the limited time available to us, we request that:

(i) Implementation of Bill 123 be delayed for so long as may be required by some of the associations to look into and to implement self-insurance programs. The Ontario Association of Architects, the Ontario Hospital Association and the ten largest accounting firms practicing in Ontario have indicated their intention to study self-insurance with a view to setting up their own programs.

(ii) Further instructions be given to study the compulsory/mandatory question to determine to what extent and when Bill 123 should be implemented.

B. PHYSICIANS AND SURGEONS

The physicians and surgeons have a mutual medical defence organization (Canadian Medical Protective Association, CMPA) which is not an insurer. A physician simply joins the Association and as a member, becomes eligible for legal counsel, payment in full of any court award or settlement and payment of costs in any legal action alleging medical malpractice. As well, the Association provides sophisticated risk management and educational services that would normally not be provided by a commercial insurance program.

While the Association has been criticized for a perceived reluctance to settle claims, statistics reveal that payments to claimants by way of settlement considerably exceed the number of court awards. By refusing to settle on the basis of economic expediency, however, the Association has discouraged nuisance claims against physicians.

At present, we are told that administration costs amount to less than 7% of total revenue. The remaining 93% is available to pay claims and legal fees. This is of course considerably higher than the 58.1% normally available for claims and legal expenses in a traditional general liability policy.

Concern has been expressed that the Association does not have a reserve fund, that it relies on annual levies against its members, and that in the future its members will be faced with crisis-level levies in order to meet claims.

This is not the case. The CMPA has a well-developed actuarially assessed reserve base which is reviewed at regular intervals. Appropriate IBNR allowances are built in using actuarial criteria. CMPA states that it has not been affected by the current insurance crisis. It requires no special assistance in operating its insurance program. It does, however, have a number of special concerns affecting the size of awards, such as gross-up, collateral benefits, limitation periods and OHIP subrogation rights, which we deal with in Part III.

C. HOSPITALS

The Ontario Hospital Association (OHA) includes in its membership some 350 hospitals and allied health institutions, including all public general hospitals in the province. Founded in 1924 as an independent, non-profit voluntary organization, OHA provides representation and direct services to assist hospitals to attain the best possible standards of patient care within given fiscal resources.

The affairs of the Association are governed by a 46-member Board of Directors comprising hospitals trustees and chief executive officers from the Association's 12 provincial regions.

Hospitals need insurance coverage for many different aspects of their operations. Insurance premium costs are paid by hospitals from the global operating budgets flowed to them by the Ministry of Health.

Hospitals require:

- — property insurance (protection of *physical* facilities and resources);
- — boiler and machinery insurance;
- — protection for losses as a result of criminal acts;
- — liability insurance (protection of *financial* resources).

Of the different types of insurance coverage listed above, only liability insurance presents particular problems at the present time.

As of March, 1986, 130 public hospitals, or 60%, obtain their insurance, including liability insurance, through the OHA-administered Comprehensive Insurance Program (CIP). The insurer under this program is Scottish and York Insurance Company. Marsh and McLennan Limited is the consultant broker.

The other major supplier of hospital liability insurance is the Guarantee Company of North America, through its broker Frank Cowan Company of Princeton, Ontario.

Major features of the CIP liability coverage are:

- — it is an "occurrence" policy, rather than a "claims-made" policy;
- — there are no deductibles;
- — there is no annual aggregate limit on claims.

Most participants in the policy have selected a limit of between $2 million and $10 million per occurrence while a few have selected limits as high as $30 million. This limit applies to both malpractice and general liability.

Participation in CIP is voluntary; each hospital decides whether or not to participate, based on its own situation and the alternatives available in the marketplace. As noted earlier, 130 public hospitals representing approximately 60% of public hospital membership of OHA, and 34 other health care organizations, are currently participating. Of these, 125 public hospitals and 32 other health care organizations hold liability policies under CIP. CIP membership during the last five years has been fairly stable at between 100 and 115 participants. Events of the last 18 months have resulted in a significant increase in the number of participants.

Availability and Premiums

There has been an alarming increase in premiums over the last five years. Hospitals participating in OHA's Comprehensive Insurance Program experienced a *25% premium increase in 1983-84 and again in 1984-85*. In *1985-86* the increase was *362%* in the basic cost of liability insurance. Because many hospitals also saw the need for higher coverage limits, the actual overall premium increase was *397%*. Further substantial increases are expected for *1986-87*.

The percentage of the total provincial hospital operating budget spent on liability insurance premiums has risen from an estimated *0.093%*, or *$3.5 million*, in 1983-84 to *0.493%*, or *$20.5 million*, in 1985-86. Projecting for 1986-87, a further 100% increase will take the figures to *$41 million* or *0.947%* of the total provincial hospital operating budget.

Ministry of Health allocations have not risen proportionately to take care of the escalating insurance costs. In 1985-86, when premiums increased 397%, the Ministry allocation only increased 3.9%. In that year the total premium cost out of the total allocation was $94,170,030. Thus it can be seen that insurance costs are having a very major impact on hospital care funding. If it continues, the Ministry allocation will have to increase in real dollars substantially or the standard of health care in Ontario will suffer significantly.

The increase in premiums is the result of increasing frequency and size of settlements and awards. In 1981 there were 11.4 claims per 1,000 beds; in 1986, it will likely be 28.3 claims per 1,000 beds. In 1981 the average claim was valued at $5,399; by comparison it is expected that the average value of 1986 claims will be $11,378. Thus frequency has increased more than 2.5 times and values of those claims have more than doubled.

It has not been a good time for the insurers. For example, in comparing the premium dollar with value of reported losses, the losses over the last five years have outstripped premium by a minimum of 200%. In 1983 losses were over 400% that of premium. In reviewing reserves it is evident that the insurers either gave too little attention to the real jeopardy or were caught off guard by expanding awards.

As a result, most of the traditional insurance markets have withdrawn. Obviously, the remaining facilities cannot provide all of the coverage required. It is the view of OHA's consultants that "traditional commercial liability insurance markets will not necessarily provide stability, long-term continuity, adequate capacity for competitive placement, nor a willingness to provide the overall quality of protection that OHA's members need".

As a result, OHA is studying other alternatives. One such alternative is to introduce significant deductibles, or a limited amount of self-insurance; establish a funded self-insurance program with a "catastrophe" insurance policy or additional policies for claims which exceed the limits of the fund; or set up a captive insurer.

Simultaneously, the Canadian Hospital Association is conducting similar studies and coordinating their efforts with OHA with a view to setting up a national facility to include British Columbia, Alberta, Manitoba, Ontario, New Brunswick and Nova Scotia.

As well, a group of Toronto hospitals has commissioned a firm of actuarial consultants to look at the problems facing hospitals in liability insurance and to suggest possible alternative approaches.

The hospitals are obviously taking their insurance problems well in hand and may well come up with a solution. We would however like to make some general comments:

(a) Because of the hospitals' expanding basis of liability it is important for them to provide a comprehensive educational and risk management service to their members. This can best be done by the professionals themselves. Consultants cannot always be expected to have the sensitive awareness of how hospitals operate and where potential jeopardy lies.

(b) Because hospitals are publicly funded, the choice of a program for the future should be as "lean" as possible. It should be as completely self-administered as possible. Every outside participant must make a profit and therefore increases the cost. A successful self-administered insurance program should be influential to the Ministry of Health when negotiating annual allocations.

(c) A reinsurance facility should be provided by the Ontario government on a commercial basis to cover catastrophic losses. Availability and costs preclude going to traditional markets for this coverage at the present. The historical statistics are so bad that it is unlikely that reinsurers will provide catastrophic cover at affordable prices for years to come. If in the future this becomes available at affordable prices, the government reinsurance facility can withdraw. Because hospitals are publicly funded it may not be appropriate (as in the case of architects and engineers) for them to reimburse the government for any losses incurred in the reinsurance program. Such reimbursement would come out of public funds. In any event the public should be prepared to come to the rescue of any hospital that suffers a catastrophic loss. Without such assistance it could likely be closed.

(d) A number of specific legislative changes should be made to fairly control the size of awards. These are discussed under Part III.

D. ACCOUNTANTS

Chartered accountants who are in public practice can be (for the purposes of insurance) classified into three groups: members who are with the large international firms, members who are practicing in small- and medium-sized firms, and members who are practicing in large domestic firms.

At this time there are basically two approaches to insurance available for the membership. The large international firms have arranged their insurance through a broker, Minet International Professional Indemnity, which looks after their individual needs on an international basis. The policies taken out by these firms have large deductibles and very high limits of insurance commensurate with the size and the possible exposures of these firms.

The small- to medium-sized firms can participate in a Canadian Institute of Chartered Accountants (CICA) sponsored insurance plan. Simcoe & Erie General Insurance Company is the insurer and Reed Stenhouse Limited is the broker. Claims are handled by Simcoe & Erie and F. C. Maltman Adjusting. We understand that the association is content with the service of the insurer and brokers.

Availability and Premiums

The main concern of the small- and medium-sized firms is reduction of coverage to their members. Originally the policy provided $10,000,000 limits, but this has been reduced to $1,000,000. We understand that Simcoe & Erie has been unable to find reinsurance above the $1,000,000 limit because the international reinsurers lump the accountants in with the bad claims experience of international accounting firms in the United States, the United Kingdom and Australia. The reinsurers do not segregate the Canadian experience from international experience, nor do they differentiate between small local practitioners and the large international firms.

Until about a year ago, the CICA-sponsored insurance plan was only one of several plans available to the small- and medium-sized firms. There were about six other competing insurance companies involved. Last year, other competing underwriters such as L. W. Biegler withdrew from the market. We estimate there were several hundred policies issued by these insurers which have not been renewed. Thus the Simcoe & Erie program is the only significant source available to small- and medium-sized firms in Canada.

It is estimated that 11% of the 3,000 small- and medium-sized firms need a minimum of $10,000,000 limit, and six firms need in excess of $10,000,000 to cover normal risks. At the same time, premiums have increased. The CICA estimates that for the reduced $1,000,000 cover, its members are paying 75% more premium this year.

The small- and medium-sized firms under the CICA-sponsored program appear content and seek no assistance.

The large international firms have never been included in the CICA program because the reinsurers have seen their risk as quite different from that of the small- and medium-sized firms. The large firms have written their individual policies through Minets. Their significant concern is limits.

Until two years ago virtually unrestricted limits were available. Some had $250,000,000 limits. This last year the limits have been reduced to $50,000,000, for which the insureds are paying four times the premium. At least one of the major firms has been reduced to $1,000,000 limits, a level simply insufficient for a professional practice with several hundred accountants doing business on an international scale. On renewal the reinsurance limits will be drastically reduced, leaving the large international firms exposed to potentially disastrous losses.

They are working with their broker/consultant Minets to form a self-insured Reciprocal. Minets is providing a ten-year claims experience to target problem claims areas.

They may try to arrange a policy written on a five-year basis with a discount or refund paid for every year that the insured remains with the insurer. Exposure above a certain limit will have to be self-insured by the Reciprocal.

To make this all possible, the large firms request that tax arrangements be available to establish a reserve with pre-tax dollars. They cite the experience in Germany where pre-tax contribution up to $500,000 may be made to build the reserve. This subject is dealt with in detail in Dr. Slater's report.

But it is the reinsurance above the self-insured layer that poses the greater problem.

There simply is no market prepared to write reinsurance for accountants at the catastrophic level. Experience worldwide, and primarily in Australia, show that losses in this class can indeed exceed $150,000,000. Unless a cap on liability is legislated, the government must provide reinsurance at these levels until the reinsurance market is prepared to do so. It may be provided on a commercial basis on condition that any losses sustained would be paid back over a ten-year period.

E. LAWYERS

In 1976 the Law Society of Upper Canada established a group errors and omissions liability insurance program. At present the individual lawyers pay a deductible ranging from $3,500 to $10,000; a group self-insured layer presently at $95,000 is provided from levies by the Law Society; an additional $400,000 is underwritten by American Home; and excess of $500,000 must be arranged by the individual law firms in the reinsurance market.

In 1981 after the withdrawal of Gestas Inc. as stop loss carrier, the Law Society set up its own inhouse administration which provides full management of the program. Staffed by a Director of Insurance and six claims examiners with considerable prior experience in the insurance industry, the administration operates in much the same way as an insurance company. The director has complete authority on all claims up to $100,000 and provides copies of reports to American Home with respect to claims between $100,000 and $500,000. The administration handles all claims through to conclusion.

We understand that American Home is content with the inhouse administration and with its own results on the program. We also understand that the Law Society is currently paying the lowest professional liability premiums on levies in Canada.

Those levies vary from $750 to $3,000 per annum per lawyer, depending on the individual members' claims experience. The following are the categories used to calculate the levy and the deductible per lawyer:

Subscriber	**Levy**	**Per Claim Deductible**
Newly Called Member	$1,000.00	$ 5,000.00
No Claims for 3 to 4 years	900.00	5,000.00
No Claims for 5 years	750.00	3,500.00
One Claim in the Last 3 years	1,150.00	5,000.00
Two Claims in the Last 3 years	1,500.00	5,000.00
Three Claims in 4 years	2,000.00	7,500.00
Four Claims in 5 years	3,000.00	10,000.00

There is however considerable concern about the excess over $500,000 self-administered layer. As discussed above, many of the significant reinsurers no longer write this business, with the result that reinsurance that was readily available to lawyers until January, 1986, is now simply unavailable. For example, Northumberland is in liquidation and Insurance Corporation of Ireland has withdrawn. American underwriters such as New Hampshire continue to write only on a selective basis.

This is so notwithstanding that, according to the information provided by the Law Society, no excess insurer was called upon to pay anything towards claims in the last four years. It is the condition of the world reinsurance liability market that makes this insurance difficult if not impossible to obtain. We understand that reinsurance premiums have increased approximately 400% to 600%. Additionally, we are advised by brokers that for a medium-sized law firm, $10,000,000 may be the maximum obtainable limits, and that the first $5,000,000 is particularly hard to place.

Lawyers' exposure is not as volatile or large as, for example, architects' and engineers'; nor are they as likely to incur catastrophic losses. It may be that the reinsurers will return to this field in the foreseeable future.

In the meantime, some initiatives have already been or should be implemented:

(a) The Law Society as of July 1, 1986, will increase the self-administered limits from $500,000 to $600,000 per claim inclusive of defence costs and pre-judgment interest;

(b) The ten largest law firms are forming a self-insured Reciprocal with $50,000,000 limits;

(c) The Ontario government should provide reinsurance on a commercial basis on condition that all losses are paid back over a ten-year period.

PART III: SPECIFIC PROFESSIONAL LIABILITY ISSUES

A. ALL PROFESSIONS

1. Joint and Several Liability

Where the professional is found liable in negligence, he becomes part of the group of persons who have contributed to the total damage. Under the *Negligence Act*, all are jointly and severally liable on a 100% basis to the plaintiff. If any member who has contributed to the damages is unable to pay his share, the professional or his insurer must contribute towards the defaulting parties' share until the plaintiff is paid in full. If he is found one per cent liable in negligence and no other party has insurance or other funds, he must pay the total judgment. This has the effect of increasing his potential payout, and at the same time encourages claimants to bring in every potential party who might be found at least one per cent liable. This in turn results in a multiplicity of parties and escalating litigation expense.

Joint and several liability has particular significance to business professionals like architects, engineers, accountants, and lawyers. In lawsuits against them, the party primarily responsible has gone out of business with the result that the professional and his insurer end up paying an unfair portion of the claim.

2. Concurrent Liability

In recent years the Canadian courts have introduced the concept of concurrent liability. This concept also has particular significance to business professionals. It allows a claimant to sue a professional either in contract on its retainer or in negligence, or both. The duty of the professional in contract is spelled out in the contract retainer and apart from certain implied terms that may be written into the contract, there are no additional terms that may be written into the contract, and there are no duties beyond the four corners of the document. In negligence, however, the professional is liable as a member of that professional discipline and his duties are determined by the performance that is expected of a competent member of that professional discipline. Thus, he may be required to warn of defective products that he has not specified, and to warn of incompetent work by contractors over whom he has no control, even though that is not one of the duties spelled out in the retainer contract. For example, in a leading case in British Columbia a Geotechnical Engineer who was retained by the architect was found derelict in his duty for failing to go over the head of the architect to warn the owner that insufficient bore holes had been taken. This duty was imposed despite the retaining contract which provided a duty only to report to the architect. The result is that the professional is exposed to duties to an ever-increasing number of people who are not in direct retainer with him, and he is exposed to even wider duties of performance expected of him as a professional, even where these are not called for in the retainer with his client.

The most serious result of concurrent liability, however, is allowing parties who are in a contractual relationship to sue each other in negligence. As soon as the action sounds in negligence, there is joint and several liability under the *Negligence Act*. Thus, a professional, who until recently was only liable for his own breaches of contract, finds himself also jointly and severally liable in negligence. The result is that the professional becomes responsible for the liability of and therefore responsible to pay up for any of the co-defendants who do not have funds or insurance to pay their share.

We recommend that the concepts of joint and several and of concurrent liability be further studied. It may be desirable to limit the results of joint and several liability only to claims between parties who are not in direct contractual relationship with each other.

3. Limitations

Lawsuits should be brought within a reasonable time. Certainly at some point, there should be an end to the possibility of litigation in any dispute.

For business professionals like architects, engineers, accountants and lawyers, the problem is that in the last five years concurrent liability has gradually been adopted in actions against them. Until concurrent liability was introduced a professional would be sued in contract by those parties with whom he had a contract. The limitation in contract runs six years from the act that constitutes the breach of contract. That event is fairly easily ascertainable.

In negligence, however, the time starts to run from the date that the claimant was actually aware of the damages that flowed from the negligence, or alternatively, from the date that the claimant, being prudent and watchful, ought in the circumstances to have been aware of the damages. This means that the negligent party can be sued many decades after the negligent act provided that the action is brought within six years of the date when the claimant knew or ought to have known of the damages.

Concurrent liability now gives a claimant who is in a contractual relationship with the professional the right to frame his lawsuit concurrently in negligence. Jurisprudence is still unsettled as to whether in these circumstances the time runs from the breach of contract or from the date that the claimant knew or ought to have known of the damages.

This uncertainty means that a professional could be sued in retirement for acts occurring early in his career, and because his errors and omissions policy is on a claims-made basis, it has also meant that a professional must maintain his errors and omissions insurance for years after he retires. With uncertainty of this kind, the insurers are unable to set rates today that can realistically account for an insured's exposure at an undetermined time in the future.

For health care professionals, the 1974 *Health Disciplines Act* introduced the so-called "discovery principles" which allow suit against doctors within one year from the date when the plaintiff knew or ought to have known the facts upon which he alleges malpractice.

As a result, it is now possible for situations to arise in which actions can be commenced against doctors long after the medical services provided have been completed.

British Columbia has recognized this problem and has legislated a special limitation for actions against hospitals and doctors running from the date of the last medical service provided.

We recommend that a similar approach be taken not only for medical professionals but for all professionals. The length of time of the limitation period — be it four years, six years, or even ten years — is not as important as a clear-cut, easily definable commencement date. The date of the last professional service provided would seem to constitute the most easily ascertainable date, and we therefore would recommend that its use be adopted for this purpose.

4. Pre-judgment Interest

While damage assessments as such are not a problem because they are, by and large, specific expenses already paid out for loss of profit calculations by accountants, there are some specific items which have increased damage and have affected prior reserves of the insurers.

The most significant of these is pre-judgment interest. It begins to run from the date of Notice of Claim and at the rate prevailing one month after the Notice has been served. A rash of Notices were served in the Fall of 1982 when interest rates were at their peak. Interest continued to run from that date at rates in excess of 20%. It is to be noted that these high interest rates followed shortly after the introduction of pre-judgment interest in 1978. If adequate reserves were set for pre-judgment interest, it would affect the total reserve immediately. If the reserve did not take pre-judgment interest into account, the insurers would start to feel the impact about three years later when claims payments would normally be made.

It is interesting to observe that the insurance industry's difficulties surfaced about two years ago, coinciding with the full impact of payments for pre-judgment interest.

Some legislative amendments should be made to protect the litigants and their insurers from:

(a) widely fluctuating interest rates in these unstable economic times; and
(b) the length of time (over which they have no control) during which litigation slowly unravels and interest continues to run.

While the rate of interest could be left to the discretion of the trial judge, it seems better to set it at a fixed rate, perhaps 9%. Otherwise, judges could use the rate as a punitive award, and litigants would have one more issue to spend time and money in argument.

The date from which pre-judgment interest runs is critical. At present it runs from service of Notice of Claim. Plaintiffs can manipulate the service to coincide with high interest rates, and can delay litigation for years knowing that they can collect interest on the award for the intervening time.

We suggest that a date be set to encourage all parties to determine as quickly as possible within the litigation process the amount of money that they are really fighting over. If interest were to begin to run from the first date on which the defendant could be reasonably expected to know the true value of the claim being made against him, it would encourage all parties to exchange damages information and conclude Examinations for Discovery as quickly as possible.

Normally the defendant would know the true value of the claim being made against him after Discoveries have been completed and medical and expert information has been provided to him, just before the first pre-trial occurs. The court often uses the pre-trial to encourage the parties to discuss settlement, and must therefore be of the view that this is the stage at which the defendant should know the case on liability being made against him and the true dollar value of the damages. Until the defendant knows this, he cannot be expected to settle and pay up. Nor should he have pre-judgment interest running against him before this date.

It is said that the defendant should pay from an earlier date because the insurer has the use of the money and the interest value of it in the meantime. We believe that:

(a) Interest should not run on a debt until the amount of the debt can be calculated;
(b) The interest value in the hands of the insurer sits in a lump sum reserve fund that is ongoing. The total interest on the fund is taken into account in settling the reserve for future claims. If it is significant, the reserve amount can be reduced and ultimately future premiums can be reduced. In other words, the interest earned does not find its way into the insurers' pockets as pure profit;
(c) While interest is running, there is not the same pressure on the claimants to move forward expeditiously with their litigation.

5. Incorporation

Some professionals are not entitled to incorporate. This seems to have been based on the philosophy that a professional performs personal services and should not be allowed to hide behind an impersonal limited liability corporation. Specifically, the accountants, lawyers, doctors and architects cannot incorporate while the engineers can do so. The result is that professionals cannot avoid paying the tax on their earnings by retaining undistributed income within their firms. In each fiscal year, the firms pay out virtually all of their profits to enable the professionals to live and pay their taxes.

If professionals were allowed to incorporate, they could be allowed to retain pre-tax earnings to provide the capital necessary to support much higher deductibles. This would in turn attract the reinsurers because they would see that the insured had a significant exposure and would likely implement stringent risk management.

We therefore recommend that all professionals be allowed to incorporate.

6. Defence Costs

A great deal of concern has been expressed by all professions about the high cost of legal and adjusting services.

There are several reasons for it.

Concurrent liability and the *Negligence Act* have resulted in greatly expanded litigation involving every possible contributor to the damages. Manufacturers of products, consultants, contractors and subcontractors, inspectors and construction managers are as a normal course added to the litigation in the hopes that each will be found at least one per cent liable. Each of them have different legal duties and each of them are entitled to separate defences. The lawyers defending one party must do so not only against the plaintiff's claim but against the claims for contribution by the co-defendants. Because the duties differ, a number of experts must be retained to study and comment on the performance of the plaintiff and of each of the defendants, as well as with respect to damages and defective products.

In addition, everyone must keep an eye to the ultimate fund available for payment. Thus each party becomes concerned about the insurance coverage of the other. Insurance denials, defences under non-waiver agreements, exclusions for certain allegations, Mareva injunctions to retain the parties' assets pending litigation and all of the other factors bearing on ultimate payment have become increasingly more complicated. Because there is usually a significant amount of money at stake, everyone vigorously defends their position.

A great deal of time and expense is expended in pre-trial preparation for very long trials. It is not uncommon for trials to take several weeks.

The courts have held that an insurer owes a duty to defend that is completely separate from its duty to provide coverage. In those cases where there is prima-facie coverage, the insurer must provide and pay for a defence even though it has strong grounds for believing that the facts will not ultimately give rise to coverage. And it must provide a defence to each of its insureds involved in the particular claim.

It is not uncommon for an insurer to insure more than one party to a professional liability action. This will certainly be so for architects and engineers now that Simcoe & Erie is by far the major underwriter in that field. Each party is entitled to separate legal representation and a defence to the claims against it. This means that there are a multiplicity of lawyers separately defending each insured and all causing the insurer to incur defence costs.

Where there are insurance issues between the insured and the insurance company, it is now becoming more common to expect the insurer to retain and pay for yet another set of legal counsel to fight out the insurance issues separately from the defence issues.

Thus the multiplicity of issues and parties, the duty to provide separate defences for each insured and the length of trials all result in extensive legal services that make the whole system expensive.

Despite this, insurers regularly make a business decision to pay more legal fees to reduce the claims rather than to fight less and pay more on the claims.

For example, in architects' and engineers' claims, the large amounts that are at stake almost always lead to full-scale defence with attendant high legal expenses.

The Insurance Bureau of Canada 1984 survey indicates that in general liability the premium dollar is allocated as follows:

Insurance Company:		
Internal claims expense	4.8¢	
Profit and Contingency	5.0	
Operating Expense	15.3	
Taxes, licences, fees	3.0	28.1¢
Brokers Commissions		18.8
Claims and Adjustment Costs		53.1
		100.0¢

National Insurance Managers tell us that claims investigation and defence costs represent 23% of claims payments. If 53.1¢ of the premium dollar is available for claims payments and defence costs, then 9.93¢ of the premium dollar is spent on legal, adjusting expert and inhouse claims handling services. If, as we believe, less than 53.1¢ of the premium dollar is available for claims (see "Tracking the Premium Dollar"), the legal costs are 23% of a lesser figure.

Legal and adjusting costs are separately set out in the financial statements of each insurer required by the Federal and Provincial Superintendents of Insurance. The results of federal insurance companies are available on a computer data base. They are broken down only into general liability expenses and do not separately set out those expenses for a professional liability specialty. We recommend that the Superintendent's form be amended to provide a more detailed breakdown of expenses into the various specialties within the general liability field and, in particular, for professional liability.

The provincial insurer's financial statements are not yet available on a computer data base. We recommend that the form be amended to give the more detailed specialty breakdown and that this be made available on the computer data base.

We note in passing that it may be misleading to compare legal fees incurred to claims payout. The lawyers are not just fighting those cases in which there has been a payout. They are fighting for the total portfolio of cases to protect the total reserve. The more successful they are, the less the payout will be. Usually success is achieved by very extensive and, therefore, very expensive litigation processes. It would be foolish to use statistics that criticize those lawyers who successfully reduce payout and support those who do little to reduce payout in order to minimize legal costs. It could only be meaningful to compare the lawyers' fees to the true dollar jeopardy that faces the insured. Without legal defence the insured would end up paying that amount. We therefore recommend that the financial statement forms be amended to provide the information required to compare defence costs to total dollar jeopardy.

7. Tracking the Premium Dollar

This is virtually impossible to do for professional liability premiums under present filing requirements. Professional liability financial data is not reported separately from general liability data in the financial filings of the insurers with the Superintendent. This has been discussed above.

In addition to considering insurers' filing requirements, the *Registered Insurance Brokers Act* requires clarification and amendment to include managers and administrators of any professional association programs. This will become particularly important as self-insurance programs are established, some of which will undoubtedly retain independent managers.

The financial data should specifically cover professional liability as a class and include in the information:

(a) Insurance company or self-insurance infrastructure costs, i.e., internal claims expense, profit and contingency, operating expenses, taxes, licences and fees;
(b) Brokers' commissions, including reinsurance brokers;
(c) External claims and defence costs, including legal, adjusting and expert fees;
(d) Administrators' and managers' commissions or fees;

(e) Claims payout after settlement or adjudication.

We were able to obtain this type of information from the Law Society of Upper Canada, which administers the insurance program for lawyers (see below). In the present fund year, the Law Society will recover approximately $11,500,000 of premium dollars. These funds will be disbursed approximately as follows:

Paid to American Home	$2,000,000
Law Society overhead	640,000
Independent adjusting costs	400,000
Counsel advice	400,000
Defence costs (defence of claims)	3,000,000
Group deductible claims payments	5,060,000

While it is otherwise impossible to provide statistically accurate data, we have gathered some information from which we can reasonably draw some conclusions:

(a) Because professional liability is more specialized than general liability, as a class it requires more effort to arrange reinsurance and to handle claims. As well, some professions have chosen to engage independent risk management services rather than doing so through their own organizations. As a result the combined cost of brokers and administrators is somewhat higher. We believe that it exceeds 25¢ of the premium dollar.

(b) Legal and adjusting fees are also somewhat higher. Although the nature of professional liability claims demand more expensive defences than in general liability, the administrators and associations together with the insurers have worked hard to control the level of costs. We believe legal, adjusting and expert fees (internal and external services combined) total 14.5¢ of the premium dollar.

(c) The higher broker/administrator and defence costs reduce the balance available for payment of claims. We believe that the balance of the premium dollar available for payment of claims is approximately 42¢. These calculations are based on the insurer's statement that investment income is its only source of profit.

Whether it is possible to improve on these figures remains to be seen. As a first step, however, full disclosure of income and costs is required. Only with this can the professions identify areas of saving and compare alternative coverages.

We note that in the past financial data has been discussed in terms of loss ratios which often exceed 100¢ on the premium dollar. The loss ratios, however, have built into them profit for various services such as brokers, administrators, adjusters, law firms, etc. This is justified since none of these can be expected to provide services without making a profit. But disclosure of income and costs is a much more meaningful way to assess the comparative value of the product than is a discussion of loss ratios.

B. HEALTH CARE PROFESSIONS

1. OHIP Subrogation Rights

The Ontario *Health Insurance Act* provides a right of subrogation for past and future medical expenses and requires an injured person to include in his malpractice action a claim on behalf of the Health Insurance Plan.

Once the supplying of health care is recognized as a state activity it could be argued that there is no more reason for an individual to pay for it (whether he is a receiver of health care or the one who caused the health care to be required) than to pay for any other state activity, except to the extent that he pays taxes.

Following the Monckton Committee Report (Report of Committee on Alternative Remedies Cmd 1946, 6860) post-war British legislation, including the National Health Service, gave up all claim to recoupment. The social welfare system in Britain, as a result, subsidizes all accident-prone activities, even those that are tortious. By this system, accident losses are distributed over the whole community.

It seems reasonable that the British precedent should be followed, abandoning OHIP's subrogation rights and adopting the consequence that costs of health care provided by the state should not be recoverable by either the claimant or the state. This solution accords with recognition of health care as a state activity.

2. "Gross-Up" for Tax on Lump Sum Awards

While this subject is dealt with in detail in Dr. Slater's report, we include information provided to us by the CMPA and the CBAO which considers the whole subject of court awards for personal injuries, taxation and frivolous actions of particular concern to medical malpractice actions.

When the Supreme Court of Canada decided the "trilogy", it made no allowance for income tax on the income from investment of the awards for personal injury. The position differed from the fatal accident cases where plaintiffs are compensated for the deceased's net, *after-tax* earnings and an allowance is made for taxes paid on investment income in the hands of the beneficiaries. Although initially the "trilogy" was taken as laying down a rule that tax was to be ignored in personal injury cases, Ontario courts are now taking the position that such an award falls short of its purpose if it does not include an amount to cover the income tax on the income from the fund. As a result, gross-up is now regularly allowed in Ontario with respect to the component for the cost of future care and prospective loss of earnings. It has been extended to the analogous situation where an allowance is made to a husband for the cost of future housekeeping services in lieu of those which would have been provided by his wife. The practice is not uniform across the country, for as recently as February 10, 1986, in *Leischner v. West Kootenay Power*, a five-judge court of the British Columbia Court of Appeal refused to allow a gross-up on an award for lost earning capacity.

As Mr. Justice Dickson put it in *Andrews v. Grand & Toy:*

> The exact tax burden is extremely difficult to predict, as the rate and coverage of taxes swing with the political winds.

As he also said, it requires

> elaborate calculations. . . to give an illusion of accuracy to this aspect of the wholly speculative projection of future costs.

The Ontario Court of Appeal, in its recent decision in *Nielson v. Kaufman*, called the calculation of the gross-up a complex and difficult process, noting:

> It involves not only assumptions with respect to the investments in the fund (e.g., bonds or corporate shares) and the amount of the other income of the recipient of the fund. . . but also such matters as the present and future federal and provincial tax rates, the range of taxable income to which the rates will apply, and the amount and applicability of exemptions and other deductions.

In the *Nielson* case, on an award for future pecuniary loss of $227,237.75, the calculation for gross-up came to $140,704. The trial judge arbitrarily reduced this amount by a contingency reduction of 25% to $105,528. The Court of Appeal reduced the future pecuniary loss to $168,391 and after applying the trial judge's contingency reduction, the gross-up ended as $71,967, thereby increasing the cost on this head of damage by approximately 43% even after a 25% arbitrary reduction.

The gross-up problem arises from the requirement that courts award a lump sum payment as the present value of a stream of future costs or allowances. The "income" on the lump sum which is taxed is as much a part of the stream of future costs as is the present value. What is required is a recognition that the compensatory payment is in two parts, the lump sum awarded after trial and the periodic payment arising by way of income on that sum. The time has come for recognition of the product of the lump sum (the periodic payment) as part of the award itself, free from tax.

The Department of National Revenue recognizes that where payments for damages have been awarded by a court or resolved in an out-of-court settlement in respect of personal injuries or death, and are paid on a periodic basis, the payments will not be considered to be annuity payments for the purposes of paragraphs 56(1)(d) and 60(a) of the *Income Tax Act* and, accordingly, no part of such payments will be treated as interest income (paragraph 13 of Interpretation Bulletin IT-365R). Similarly, the Department recognizes that retiring allowances to an employee, also tax free, need not be by a single payment (paragraph 12 of IT-337R2). Surely the purpose of the receipt should be recognized over and above the time and means by which it arises and be acknowledged in a revised departmental Interpretation Bulletin. If necessary, the original funds (the lump sum) could be segregated and hedged about just as an RRSP or RHOSP so that the taxation authorities will be able to differentiate funds derived from such sources and be assured they are used for the intended purposes.

3. Structured Settlements as an Alternative to Lump Sum Awards

By Section 129 of the Courts of Justice Act, Ontario courts may order periodic payment of certain awards for damages, including awards for personal injuries, but only with the consent of all affected parties.

The advantages of structured settlements, the most common form of periodic payments, are well known. Principally they eliminate the need for gross-up for income tax and remove the need for administration fees, both of which add needlessly to the cost of awards and settlements.

However, Section 129 is deficient in that it does not provide power in the courts to impose structured settlements without consent of the parties. Power in the court to provide for a structured settlement, or its equivalent, without consent of all parties but in the best interests of all parties in the exercise of judicial discretion, is required to effect the full potential of this beneficial innovation.

The result of withholding power from the courts to act without consent of all parties has been that in some cases, particularly in settlement of claims on behalf of infants, annuities have been required by persons acting for them with a guaranteed term certain of long duration (say, 30 years) and with a further provision that if the infant does not survive for the guaranteed period then the payments are diverted to others. Not only do such lengthy periods of guarantee greatly increase the cost, but they mean that monies obtained on the basis that they will be used for future care or other specific purpose may not be used for their intended purpose and constitute a windfall to others. Presumably the courts would not countenance this perversion of the compensation process.

4. Collateral Benefits in Judgments

In 1973 the Ontario Court of Appeal confirmed that a defendant in an action could not take advantage of outside benefits which had been received by a person who had been injured. This ruling has permitted plaintiffs on occasion to receive double recovery under various heads of damage. Mr. Justice Montgomery of the Ontario Supreme Court stated in a recent judgment that the *Family Law Reform Act*, the pronouncements in the "trilogy" and pre-judgment interest all have vastly increased the size of court awards and it is time for the Court of Appeal again to consider the issue of collateral benefits.

Others have commented that the present approach to the problem of collateral benefits is eessentially punitive in character and is at odds with the increasing emphasis established by the Supreme Court of Canada "trilogy" on the need to compensate the plaintiff *only* for his *actual loss* and provide for his actual needs. Plaintiffs should be prevented from taking advantage of duplication of payments which they may have received from other sources, (e.g., disability insurance, welfare payments, re-training programs, etc.).

There should be no overlap between tort compensation and social security benefits. This was the conclusion in the Report of the Pearson Commission (Royal Commission on Civil Liability and Compensation for Personal Injury, Cmnd 7054-I). At paragraph 475 the Commission said:

> We think the time has come for full coordination of the compensation provided by tort and social security. An injured person, or his dependents, should not have the same need met twice, not only because it is inequitable but because it is wasteful. *This principle has been adopted in most countries where compensation may be provided through both tort and social insurance.*

The recommendation for the elimination of overlap between tort and social security would, the Commission noted, bring about a substantial saving of costs (paragraph 541) and would affect the levels of individual awards (paragraph 542).

By both statute and judge-made law, both before and since the report by the Pearson Commission, the British have been moving to reduce damages for personal injuries by taking into account benefits provided by the state.

5. Discount Rate

In attempting to determine the present value of sums of money to be available in the future, courts in Ontario apply a 2.5% per year discount rate. This is intended to represent the difference between the anticipated investment interest rate and the rate of inflation. Many now feel this rate is entirely inappropriate and does not reflect present-day inflation rates and anticipated investment income.

Rather than a 2.5% discount rate, a 3.5%, 4.5% or even 6% rate could be seen as more realistic.

In a recent Judgment in the Supreme Court of Ontario *(McDermid v. Csomor)* Mr. Justice Rosenberg allowed a discount rate of 6% in keeping with the realities of inflation and investment income. The discussion of discount rates in the Reasons for Judgment in this action are worthy of consideration.

An example of the impact of the discount rate on awards for personal injury is to be seen in a Judgment in *De Champlain v. Yamka*. In this Judgment, Mr. Justice Montgomery applied a discount rate of 2.5% for the costs of future care of a badly disabled patient. At this rate the total costs of future care amounted to $1,241,837. If higher discount rates had been applied the amounts would have been as follows:

3.5% — $1,026,982
4.5% — 865,284
6% — 690,099

It is suggested that present discount rates should be reviewed by economic and actuarial consultants to determine if current rates are appropriate. The Rules of Practice should then be amended appropriately.

6. Examination of Legal Aid Procedures

Legal Aid should not lend support to a claimant who has a frivolous cause of action.

More than 50% of the medical malpractice lawsuits with which CMPA deals and which are brought to a conclusion each year are terminated without payment of an award or settlement. It is clear that many of these were without legal merit, something which should have been recognized by the plaintiff relatively early in the course of the lawsuit. It appears that a significant number of these cases are prolonged unnecessarily because the plaintiff insists on continuing at no financial cost to himself and legal aid authorities authorize this continuance.

When ultimately the plaintiff discontinues an action which has no legal merit, it is futile to attempt collection of costs because the plaintiff is impecunious.

Legal Aid has discretion to pay such costs and attempt to recover them from the plaintiff, but this discretion is only exercised where the defendant has personally suffered financial hardship. Of course, this cannot be demonstrated where the CMPA is defending the doctor.

We recommend that where Legal Aid allows a claimant to continue an action against a physician, Legal Aid should be responsible for payment of any costs awarded against the unsuccessful claimant.

In addition, we recommend that the Rules of Practice be amended to allow the court to direct the filing of security for costs against a plaintiff *who resides within the jurisdiction* in appropriate cases. At present, the only remedy against a resident plaintiff is an order striking out the action if it is frivolous. Since this deprives the plaintiff of his day in court, the order is issued only in the clearest of cases. Where the court has concern that the case may be frivolous it should allow the case to proceed only if after dismissal, the claimant has the ability to indemnify the defendant for his costs. An order for security would achieve this.

7. Family Law Legislation

This subject has been addressed in other submissions to the Task Force. The general concerns can be summarized as follows:

(a) The effect of the legislation is to increase the potential group of unknown claimants;

(b) Where there is an award or settlement in favour of a partially or totally disabled plaintiff, this legislation can result in "double compensation" to the plaintiff's relatives, already compensated under the legislation, who inherit the balance of the award or settlement upon the plaintiff's demise.

As to the second of the above concerns, we recommend that amendments be considered to effect a similar system to that under the Workers' Compensation legislation whereby expense benefits cease upon the injured worker's demise.

8. Hospital Liability

Traditionally, hospitals have not been liable for a physician's negligence if the physician was an independent practitioner and not an employee in the usual master and servant relationship.

There is a clear trend towards imposing "corporate liability" on the hospitals for the negligence of the medical or dental staff regardless of any employer/employee relationship. In the Ontario case of *Yepremian vs. Scarborough General Hospital*, Mr. Justice R. E. Holland found the hospital liable for the negligence of an independent physician on its specialty medical staff. The hospital provided an emergency department and a roster of general and specialist physicians to be available for the medical care of any patients who were presented. This patient did not choose the physician. The physician was found by the court to have been clearly negligent. On appeal, the higher court overturned the trial judgment by a 3 to 2 decision. Although this result left the traditional law in place, it shows that six Ontario Supreme Court justices were split 3 to 3 on the issue. The case was settled out of court in favour of the plaintiff and thus not allowed to go to the Supreme Court of Canada.

A current Statement of Claim, filed June 1985 with the Registrar of the Supreme Court of Ontario, alleges among other things that the several physician defendants are hospital employees or, if not, the hospital is vicariously liable because the patient did not choose the physicians who cared for him, and that they were an integral part of the organization of the hospital providing services which the public as a whole and this patient in particular expected from the hospital.

This notice of corporate liability essentially began in the United States through a judgment by the Supreme Court of Illinois, September 1955, in the case of *Darling vs. Charleston Community Memorial Hospital*. An eminent Manitoba judge wrote of the importance of the case in the October 1970 issue of *Canadian Hospital*. In OHA Report on Legislation No. 233 November 5, 1970, on this article about the Darling case, the following appeared:

> Hospitals are no longer seen as passive parents who *only provide facilities*.

The court, in the case referred to, quoted from an opinion by a New York court as follows:

> The conception that the hospital does not undertake to treat the patient, does not undertake to act through its doctors and nurses, but undertakes instead simply to procure them to act upon their own responsibility, no longer reflects the fact. Present day hospitals, as their manner of operation plainly demonstrates, do far more than furnish facilities for treatment.

This, therefore, makes the case that much more deserving of careful study and application. Although the law and legal procedures in the U.S.A. differ in some respects from those in Canada, the basic facts in this case relating to the responsibility of the hospital cannot be overlooked.

Some specialists in hospital laws advise us that if corporate liability is not in fact here in Ontario, it is on the immediate horizon and that this view is held by medical liability insurers.

We note that Mr. Justice Dubin in the Dubin Report on the Hospital for Sick Children expressed his personal opinion that there should be statutory changes to make hospitals liable for the practice of medicine by physicians in a hospital.

Clearly the courts are moving towards corporate liability for the hospitals.

This has a profound impact on insurance. Without corporate liability the negligence of independent doctors affects only the CMPA. If corporate liability is imposed, the negligence of independent doctors will also affect the hospitals' insurance program. Whether we are to have hospital corporate liability or not should be resolved. It cannot be resolved fairly without hearing from all those who may be affected, including the CMPA, the OHA, the Dental Association, insurers, etc.

We recommend that action be taken to remove the uncertainty by legislation after appropriate study.

PART IV: LIST OF RECOMMENDATIONS

1. Government-sponsored commercially based reinsurance facility for self-insured programs.
2. Amendments to financial reporting requirements.
3. Further study of mandatory/compulsory insurance requirements.
4. Tax amendments to accelerate reserve buildup of self-insured programs.
5. The concepts of joint and several and of concurrent liability should be further studied.
6. The limitations period for all professionals should commence to run from the date of last professional service.
7. Pre-judgment interest rates should be fixed and commence to run from the first date on which the defendant could be reasonably expected to know the true value of the claim being made against him.

8. Professionals should be allowed to incorporate.
9. OHIP's subrogation rights should be abolished.
10. Gross-up should be modified.
11. The court should be empowered to impose structured settlements even where it does not have the consent of the parties.
12. There should be no overlap of tort compensation and social security or other collateral benefits.
13. Present discount rates should be reviewed by economic and actuarial consultants and revised if appropriate.
14. Legal Aid in some circumstances should be responsible for third-party cost awards.
15. The Rules of Practice should be amended to allow an order for Security for Costs against resident plaintiffs in some circumstances.
16. Amendments to the Family Law Legislation should be made.
17. The issue of hospital corporate liability should be studied and resolved.

APPENDIX 11

REPORT TO THE TASK FORCE ON INSURANCE ON THE ONTARIO PRIVATE PASSENGER AUTOMOBILE BODILY INJURY CLAIMS STUDY

(IBC DATA BASE)

April 17, 1986

The Wyatt Company
and Cassels, Brock & Blackwell

I. Requirements of Task Force

The general insurance industry in Ontario has argued that both price increases and decreases in capacity result, in large part, from increases (over and above inflation) in the costs of claims arising from bodily injury (whether automobile-related or otherwise). The industry position is that such increases can be explained by two broad factors:

- increases in the amounts awarded over time for general damages in respect of comparable injuries; and
- the addition of new categories for recovery of costs (and increases in the amount awarded within such categories), i.e., introduction in 1977 of a statutory entitlement to pre-judgment interest and in 1978 of dependant's claims.

In support of its position, the industry points to certain court judgments, to legislative changes and to its general underwriting losses. This evidence, however, does not prove that there is any causal relationship between the factors described and the worsening loss experience. As a result, the Task Force requested that research be undertaken for the purpose of establishing, statistically, the causation and extent of the increases.

II. Sources of Data

While many court judgments are included in published reporting services, such judgments represent only a fraction of claims made. Very few claims actually are resolved by a court, and not all of those are reported (usually only cases of precedential value are reported). Reported cases do have a "multiplier effect" because court awards influence out-of-court settlements in similar cases. A study of reported cases, therefore, would be of very limited use in analyzing bodily injury claim results because of the relatively small number of cases involved and the difficulty of identifying comparable cases.

One of the major reasons why court awards have a "multiplier effect" is that there are publications which, on a periodic basis, list the quantum of general damages for any given injury. (See, for example, Goldsmith's *Damages for Personal Injury and Death in Canada*.) Such comparisons are not cumulative and they do not include information on other bases for recovery, e.g., pre-judgment interest.

The sources designed for use by lawyers in pursuing bodily injury claims, therefore, are not appropriate for establishing statistically the relationship between damages and losses. The only other body of data on claims is that maintained by the Insurance Bureau of Canada ("IBC").

All private insurance companies are required to report automobile premiums and claims experience to the IBC according to the statutory Automobile Statistical Plan.

The IBC compiles these submissions and produces various reports and exhibits which are used by the insurance industry.

However, the data base maintained by the IBC does not categorize claims information by type of injury nor provide a breakdown of the components of claim payments (e.g., general damages, *Family Law Reform Act* payments, etc.).

This information is only available in the individual claim files themselves.

Therefore, it was decided to request access to actual claim files in large insurance companies with the objective of determining the influence of various factors on rising insurers' claim costs over an eight-year period (1976-1984).

III. Methodology

The IBC provided a listing of all private passenger automobile claims larger than $1,000 experienced by five major insurance companies, selected by us, allocable to policy years 1976, 1980 and 1984.

Rather than proceeding directly with an investigation using claims experience from the five companies, one was chosen to provide assistance as a pilot project.

Consequently, 150 claim numbers from each of policy years 1976, 1980 and 1984 were selected, including from each year 75 claims larger than $50,000.

The company made available claim files corresponding to the selected claim numbers to an experienced lawyer for detailed analysis using a questionnaire created for this purpose (see exhibit 1).

The information from completed questionnaires was compiled into a data base, producing the results shown in Table 3.

IV. Results and Recommendations

The following tables are attached.

Table 1: IBC Size of Loss Distribution — Bodily Injury Claims (Ontario) — Valued at December 31, 1984

Table 2: Data for Five Companies

Table 3: Sample Company Analysis

Table 4: Development of 1984 Policy Year Data

Three significant factors affecting the outcome of the study should be noted:

a) Insurers generally, and the company studied in particular, have implemented file destruction procedures for closed files. As the bulk of claim files for 1976 are closed, the bulk of those files have been destroyed. Very few open files remain. Tables 2 and 3 therefore are based only on the 1980 and 1984 policy years. The study therefore is missing its "anchor" in 1976, a year pre-dating certain statutory changes discussed above.

b) The claims for the 1980 policy year are reasonably well developed but many claims in the 1984 policy year are yet to be settled. While the average claim size (Tables 1 and 2) appears to be relatively constant between 1980 and 1984, the 1984 experience is understated due to the fact that no estimate is included of claims which have occurred but are not yet reported and future development on claims that have been reported. This development is approximated and a comparison of 1980 with 1984 is shown in Table 4.

c) The 1980 policy year claim files generally did not include a breakdown of the final settlement figure, preventing comparison of the amounts for 1980 to the 1984 amounts (Table 3, "Claims Allocation By Component").

The study, therefore, suggests that it is impossible to prove statistically: (a) whether general damages for comparable injuries have increased losses and, if so, at what rate; and, (b) to what extent new categories for recovery have increased losses. Even if an adequate number of claims for the 1976 policy year were available, the study shows that it is unlikely that the total settlement figures would be broken down with sufficient particularity to allow comparison through 1976, 1980 and 1984. We are of the opinion that the amount of detail available from the files is unlikely to be any more satisfactory in any other company or companies because the industry has reasonably consistent practices.

The study does highlight several matters:

1. **Increase in Average Claim Size — Industry (Table 1)**

	Increase in Average Claim Size	**Increase in Consumer Price Index (2)**
1976/1980	46.2%	41.4%
annualized	10.0%	9.0%
1984/1980 (1)	43.1%	37.7%
annualized	9.4%	8.3%

(1) 1984 claims have been adjusted to reflect future claims development (see Table 4).
(2) The increase in CPI is based on information produced by Statistics Canada.

This chart shows that the average third-party liability claim has increased by about 7% more than the Consumer Price Index during 1976-1984.

2. **Variance in Average Claim Size — Five Companies (Table 2)**

While the five-company total average claim size corresponds well with the total industry's average, there is much variance within the five. This variation might be the result of many factors, such as variation in

- claims management and methods;
- marketing and underwriting emphasis;
- chance fluctuations.

3. **Sample Company Analysis (Table 3)**

(a) There appears to have been a fair degree of consistency between 1980 and 1984 in the types of injury in proportion to the total number of claims.

(b) The "Legal Process" portion of Table 3 for policy year 1980 shows that it is usual for a claimant to have a lawyer. Legal actions were initiated in only 32% of the 1980 claims under $50,000, although that figure rose to 100% for claims over $50,000. Only 2% of the claims under $50,000 had reached trial by March 1986. None of the claims over $50,000 had reached trial by March 1986. The experience and ability of the lawyer for the claimant can be a factor in increasing the amount of the claim over and above the norm. Innovation is more likely to occur in the larger claims.

(c) Only 45% of the claims under $50,000 are handled expeditiously by the claimant, while that figure drops to 22% for the claims over $50,000. Similarly, adequate and timely disclosure to the insurer is more likely to be made in the smaller claims (75%) than in the larger claims (44%). Interestingly, the insurer, in our judgment, made a reasonable and timely offer to settle in 68% of the cases under $50,000 (adequate and timely disclosure having been made in 75% of those cases). It should be noted, however, that advance payments are used by the insurer only in a small percentage of cases.

(d) Comparing the 1980 and 1984 policy years in the "Legal Process", "Insurance Company Initiatives" and "Evidence of Collateral Benefits" sections of Table 3 should be done while remembering that there are 1984 claims unreported at December 31, 1984 (most likely, claims over $50,000).

In summation, this study has shown that it is not possible, due to lack of detailed historical information, to identify the legal factors driving the increases in claims costs and to show their effects statistically.

EXHIBIT 1

CLAIMS CHECKLIST
(Per Claimant)

General:

Claim Number: ____________________

Policy Year: ____________________

Accident Date: ____________________

Total Claim: Paid ____________________

Reserve ____________________

Total ____________________

Company Number: ____________________

Territory: ____________________

Policy Limit: ____________________

Claim: Open []

Closed []

Type of Injury:

Soft Tissue [] 1.
(3 month disability)

Knee [] 2.

Psychic Trauma [] 4.

Back [] 3.

Catastrophic Injury [] 5.

Allocation by Component:

	Amount		Amount
1. General	____________	5. P.J.I.	____________
2. Special (excl. wages)	____________	6. Legal Costs	____________
3. Wages	____________	7. Other Costs	____________
4. F.L.R.A.	____________	8. Gross Up?	____________

Has there been adequate and timely disclosure made to allow the Insurer to commence payment? Yes [] No []

Process:

1. Lawyer? Yes [] No []
2. Action Commenced: Yes [] No []
3. Trial? Yes [] No []
4. Location of Trial ____________________
5. Judge [] Jury []

Insurance Company Initiatives

1. Reasonable and timely offer to settle? Yes [] No []
2. Advance Payments? Yes [] No []
3. Structured Settlement Yes [] No []
4. Delay Tactics? Yes [] No []

Claimant Action:

1. Is there evidence of collateral benefits? Yes [] No []

   If yes, what type?

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2. Was claimant's solicitor a factor in amount of settlement? Yes [] No []

   If yes, positive [] negative []

3. Was there any evidence of innovation? Yes [] No []

   If yes, medical [] legal []

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1. Was claim advanced expeditiously? Yes [] No []
2. Did the New Rules have any effect on outcome? Yes [] No []

   If yes, describe:

General Remarks:

ONTARIO PRIVATE PASSENGER AUTOMOBILE BODILY INJURY LIABILITY CLAIMS STUDY VALUED AT DECEMBER 31, 1984

TABLE 1

INDUSTRY DATA LOSS DISTRIBUTION

	1976			1980			1984		
Size of Claim	#	$	Avg.	#	$	Avg.	#	$	Avg.
1,001 – 5,000	9,479	26,342,102	2,779	12,754	38,024,818	2,981	13,185	43,042,173	3,264
5,001 – 10,000	3,005	23,258,209	7,740	5,318	41,557,976	7,815	7,008	54,701,937	7,806
10,001 – 25,000	1,808	30,503,676	16,872	3,986	66,358,414	16,648	4,880	78,585,516	16,104
25,001 – 50,000	607	22,365,862	36,847	1,224	45,600,950	37,256	1,236	44,952,599	36,369
50,001 – 100,000	271	19,585,416	72,271	586	43,797,493	74,740	458	33,200,682	72,491
100,001 – 250,000	85	10,991,140	129,307	280	40,315,449	143,984	170	25,048,054	147,341
250,001 – 500,000	26	7,910,751	304,260	136	41,203,921	302,970	127	39,728,437	312,822
500,001 – 1,000,000	1	563,174	563,174	20	12,293,030	614,652	34	20,648,627	607,313
over 1,000,000	0	0	0	0	0	0	4	4,924,207	1,231,052
Total	15,282	141,520,330	9,261	24,304	319,152,051	13,543	27,102	344,832,268	12,723
# cars insured	2,863,082			3,420,996			3,782,117		
# claims/1,000 cars insured	5.34			7.11			7.17		

NOTES: 1. All data is based on information supplied by Insurance Bureau of Canada (IBC).

2. Data does not include any estimate for future loss development. (This will have greatest impact on 1984 year.) See Table 4.

3. Claims are valued at December 31, 1984 (June 30, 1985, close off).

ONTARIO PRIVATE PASSENGER AUTOMOBILE BODILY INJURY LIABILITY CLAIMS STUDY

TABLE 2

DATA FOR FIVE COMPANIES

	1976 POLICY YEAR ONTARIO CLAIMS > $1,000			1980 POLICY YEAR ONTARIO CLAIMS > $1,000			Change in Average Claim		1984 POLICY YEAR ONTARIO CLAIMS > $1,000		
Company	Claims Incurred	Approx. Number of Claims	Average Claim	Claims Incurred	Approx. Number of Claims	Average Claim	80/76	Annualized	Claims Incurred	Approx. Number of Claims	Average Claim
1.	$8,170	825	$9,910	$15,027	1,075	$13,980	41.1%	9.0%	$15,790	955	$16,535
2.	15,898	1,780	8,925	38,058	2,540	14,985	67.8%	13.8%	34,728	2,490	13,945
3.	6,927	865	8,010	13,091	1,360	9,625	20.2%	4.7%	17,394	1,720	10,115
4.	3,445	380	9,065	11,665	700	16,665	83.8%	16.4%	16,648	1,300	12,805
5.	16,741	1,425	11,750	36,988	2,590	14,280	21.5%	5.0%	13,094	1,090	12,015
TOTAL:	$51,181	5,275	9,700	$114,829	8,265	$13,895	43.2%	9.4%	$97,654	7,555	$12,925

NOTES:
1. No factors applied for OHIP, future development etc. but includes claims expenses and reserves.
2. Data supplied by the IBC on a *CONFIDENTIAL* basis.
3. The five companies represented about 32% of the Ontario private automobile market in 1984.
4. All data is valued at December 31, 1984 (June 30, 1985 close off).

ONTARIO PRIVATE PASSENGER AUTOMOBILE BODILY INJURY LIABILITY CLAIMS STUDY

TABLE 3

SAMPLE COMPANY ANALYSIS

	1980 POLICY YEAR		1984 POLICY YEAR	
	Under $50,000	$50,000 and Over	Under $50,000	$50,000 and Over
Average Claim in Sample	$7,343	$110,962	$8,300	$113,840
No. of Claims Analyzed	44	9	93	26
Claims Allocation by Component				
1. General	N/A	N/A	69%	35%
2. Special			3%	–
3. Wages			11%	26%
4. F.L.R.A.			3%	18%
5. P.J.I.			2%	10%
6. Legal Costs			11%	11%
7. Other Costs			1%	–
8. Gross-Up			–	–
Type of Injury				
1. Soft Tissue	89%	56%	84%	54%
2. Knee	9%	33%	11%	35%
3. Back	34%	56%	38%	15%
4. Psychic Trauma	5%	22%	8%	12%
5. Catastrophe	0	–	0	15%
6. Fatality	0	11%	3%	12%
Legal Process				
1. Lawyer?	82%	100%	71%	85%
2. Action?	32%	100%	18%	62%
3. Trial?	2%	–	–	–
4. Solicitor a factor?	55%	78%	15%	19%
5. Innovation?	–	11%	–	4%
6. Expeditious?	45%	22%	48%	31%
7. New Rules Affected?	5%	–	2%	4%
8. Adequate and Timely Disclosure to Insurer?	75%	44%	58%	46%
Insurance Company Initiatives				
1. Reasonable and timely offer to settle?	68%	33%	66%	31%
2. Advance Payments?	14%	11%	5%	23%
3. Structured Settlements?	2%	–	–	–
4. Delay Tactics?	–	–	–	–
Evidence of Collateral Benefits	11%	–	8%	19%

ONTARIO PRIVATE PASSENGER AUTOMOBILE BODILY INJURY LIABILITY CLAIMS STUDY

TABLE 4

DEVELOPMENT OF 1984 POLICY YEAR DATA

	Number	Amount	Average	No. of Claims/000 Cars Insured
1984 (no development – at 18 months maturity)	27,102	344,832,268	12,723	7.17
Factor used to bring to same maturity level as 1980 (66 months)	1.095	1.668	–	–
1984 (developed – to 66 months maturity)	29,677	575,180,233	19,381	7.85

The factors used were derived from the 1984 "Green Book" using Ontario selected private passenger BIPD factors to move from 18-30 and 30-42 months maturity and countrywide BIPD factors to move from 42-66 months maturity.

	Losses	Claims
18-30	1.351	1.097
30-42	1.154	1.000
42-66	1.070	.998
18-66	1.668	1.095

APPENDIX 12

THE QUEBEC AUTOMOBILE INSURANCE SYSTEM

In March 1978, Quebec introduced a new *Automobile Insurance Act* that completely abolished the fault system for the compensation of automobile accident victims for bodily injury. The system is publicly administered by La Régie de l'assurance automobile du Québec.

Insurance coverage takes two forms: a basic compulsory public plan and a supplementary elective private plan to provide no-fault insurance for those who do not believe themselves to be adequately covered by the basic plan. The basic plan pays unlimited indemnities for medical and rehabilitation costs not covered by other public plans, and limited amounts for injuries, dismemberment, and pain and loss of enjoyment of life. There is a maximum indemnity (which was estimated to compensate the total loss of income of 85% of the population in 1978) for disability and death benefits. The indemnities are paid in the form of indexed annuities, after a waiting period of one week (a type of deductible in order to eliminate minor claims and, then, to reduce premiums). Annuities are not taxable and the maximum paid to an individual represents 90% of his net income up to a maximum gross income ($18,000 in 1978 and $33,000 in 1985) – that is, the total net income less the expenses inherent in going to work. The compensation table for accidents in Quebec (1985) is attached herewith.

Persons at home, unemployed persons, retired persons, students and minors receive income replacement benefits even if they are not in the work force. In case of death due to automobile accidents, the regime pays funeral costs up to a certain maximum as well as compensation whether or not a person supports a family. However, the levels of compensation are not the same in both cases.

These plans are in lieu of all rights: no action is permitted before any court of law. A claimant who disagrees with the decision of the officer of La Régie concerning compensation may apply to La Régie to have the decision reviewed.[1]

The pricing of the insurance in the basic plan involves a set premium for a given class of vehicle regardless of the risk represented by the individual, his past experience and so forth. Since March 1983, however, a driver without demerit points and criminal infractions over the previous two years is eligible for a discount of $5 on the renewal cost of his driver's licence. The main sources of financing are fees for drivers' licences and automobile registration fees. A tax on gasoline was used before March 1982. Another source of funds is interest revenues.

Quebec also opted for a system of partial no-fault insurance for property damage. This remains administered by the private industry, specifically the Groupement des assureurs automobiles — a consortium of private insurers established by legislation.

Under this system individuals are required to purchase insurance for damage to property. This insurance provides coverage for the driver's damage to vehicles other than automobiles and compensates the driver who is not at fault for his vehicular damage. The fault is determined by a schedule of typical accident situations. The driver who is at fault compensates the driver who is not at fault for his vehicular damage. The driver who is at fault is compensated for his losses only if he purchased voluntary collision coverage. Drivers who are at fault will incur the loss of the deductible if they have collision and will pay the entire cost if they have no collision coverage.

The property damage provisions eliminate third-party compensation for vehicular damage. They provide coverage for one's own damages, depending on a simplified fault determination process. This system is similar to the Ontario system for those with collision insurance, provided there are no injuries. In Ontario two insurance companies will deal with collision claims in much the same way as in Quebec. The difference occurs for those without collision coverage. In Ontario the individual would have to bring his own claim against the other person's insurance company if he is not at fault. In Quebec one's own insurance company would provide benefits based on a simplified fault system. As Sam Rea notes, the costs of obtaining compensation should be lower in Quebec for those not at fault (and without collision insurance).

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[1] There is then a right of appeal to the Commission des affaires sociales, whose decision is final.

(In both provinces, insurance premiums are based on claims experience and traditional risk classifications such as age, sex, marital status, territory, type and use of cars.)

Pursuant to the Direct Compensation Agreement all insurers have waived subrogation rights among themselves except in some unusual situations. And a dissatisfied insured may have legal recourse only against the insurer in compliance with standard rules and procedures. This may involve an Arbitration Board of the Groupement, the decision of which is final.

This quantum leap in the basis for personal injury and property damage compensation was not taken precipitately. In 1973, the Gauvin Committee of Inquiry on Automobile Insurance concluded that under the then existing fault/tort regime, 28% of individuals who suffered economic losses were not compensated and victims who were not at fault received a maximum of 60% compensation for economic losses (p. 200). The Committee also emphasized long delays before compensation was paid out. Finally, the high administrative costs were deemed unacceptable and excessive. Total administrative costs, including selling expenses (agents' commissions), underwriting and policy processing and general administrative costs, represented 34% of premiums, compared to only 16% in Manitoba for the same period.

Ultimately, the new Parti Québécois government accepted the main recommendations of the Gauvin Committee with one important addition: basic insurance for bodily injury is managed by a single state-owned company — La Régie. It is appropriate now to review briefly the advantages and disadvantages of the Quebec system with the benefit of eight years' experience.

A recent study of the Quebec system has been prepared by two University of Montreal professors: "L'Assurance automobile au Québec: Bilan d'une Réforme" by Claude Fluet and Pierre Lefebvre (February 1986). This is attached as Appendix 13. It would be useful to highlight their findings.

In general, the authors conclude that the record of the Quebec automobile insurance system has been positive: the overall protection has been increased, the appreciable efficiency gains have allowed the relative cost to diminish, and the quality of the compensation procedures has improved significantly. Indeed, in retrospect it seems that the three fundamental choices made by the government in establishing the regime (the total abolition of tort actions and the notion of fault, limits on recovery for non-pecuniary losses, and the public administration of the regime) have been justified.

With specific reference to the no-fault bodily injury system, the following observations are most pertinent:

- Since 1978, the public regime has collected 93% of total insurance premiums and distributed 97% of net compensation payments. The residual part provided by the private sector relates to supplementary private disability and special coverage in respect of accidents outside Quebec.
- The proportion of automobile accident victims receiving compensation has increased by 20%, from 41% to 50%. Almost all severely injured victims are totally compensated.
- The delays in compensation have been considerably reduced: under the old regime, 65% of victims had received no compensation 6 months after the date of the accident; under the new regime, this is down to a mere 4%.
- The compensation level per victim has risen approximately 14% under the new system. Taken together with an increase in the frequency of compensation of some 18%, this represents an increase of 35% per victim.
- The relative cost of insurance (including administrative costs) per dollar of compensation has significantly diminished, from 1.63 to 1.13. And the relative price of

insurance has diminished in the same proportions. This reduced cost is explained in terms of the abolition of the fault principle, and the consolidation of administration in a public body.

- Comparing the period 1973 to 1977 with that of 1978 to 1984, the ratio of expenses to net compensation has been reduced by 4% for property damage and by 36% for bodily injury, for a total reduction of 15%.
- Insurance premiums have risen in real terms between 1978 and 1984. The average premium for bodily injury increased by 1.5%, and the average premium for property damage by 6.7%.

The study also set out a comparison of the Quebec regime with the regimes in Ontario, Manitoba, Saskatchewan and British Columbia. Its findings suggest, among other things, that the portion of the premium dollar returned to the insured in Quebec is much higher than in Ontario and somewhat higher than in the western provinces.

This brief discussion of the Quebec model should include a brief assessment of the experience with the property damage regime since 1978. In this connection, Fluet and Lefebvre make the following observations:

- The new law has not had a significant effect on the number of insurers carrying on business in Quebec. For example, the five largest insurers still account for about 35% of the market.
- There has been an increase in the number of vehicles insured (from 90% to 98%).
- The return to the insured, measured by ratio of net compensation to premium, has increased from 58% in 1973–1978 to 67% in 1979–1984. The inverse ratio — premiums paid per dollar of net compensation — has fallen from 1.74 in 1973–1978 to 1.50 in 1979–1984 — a reduction of 14.8%.
- There has been a small reduction in the ratio of cost d'exploitation/total expenditures from a 38% average in 1973–1978 to 34% in 1979–1984. This is an indication of the increased efficiency of the new system. More specifically, a little more than half of this reduction in the relative price of property damage insurance can be attributed to a reduction in the ratio of premiums to total expenses, while a little less than half can be attributed to the reduction of the ratio of total expenditures to net compensation.

In conclusion, the Quebec experience with a no-fault, no-lawsuit automobile insurance system for bodily injury compensation, and a rather unique partial no-fault regime for property damage, appears to be generally positive. Virtually everyone consulted by the Task Force in Quebec commented favourably on the system, whether they were beneficiaries of the system, or from within government, the insurance industry, and even the legal profession itself.

The main focus of criticism has been on the failure to devote more resources to safety education and to strengthen the very weak bonus-malus system, whereby a driver with good experience is entitled to a mere 4% reduction on his annual premium. These areas are now apparently receiving much greater attention.

In addition, there is concern that the compensation levels are inappropriate: too rich for some, while inadequate for victims such as young professionals at the beginning of their working career. In this connection, La Régie is in the process of preparing a proposal to rebalance the compensation levels. It should be noted parenthetically that the compensation levels for workers are now fully integrated with that of the workers' compensation scheme.

The other area where change may be anticipated is in respect of the possible privatization of some of the functions of La Régie. Although most observers are generally complimentary of La Régie's operations, particularly in respect of its efforts at rehabilitation and so forth, most private insurers believe that the private sector could deliver the services more efficiently and effectively, and could provide the consumer with greater choice in terms of the type of disability insurance package he or she might want to purchase. It must be noted, however, that none of the proponents of privatization recommend a return to the tort system in any way, and they fully expect the government to continue to mandate minimum compensation levels.

Finally, with respect to property damage, once again there is general agreement that the direct-compensation, no-subrogation system is more efficient and is working well. Some modification to the structure of the Groupement des assureurs has been mooted insofar as its activities overlap with those of the Quebec Branch of the Insurance Bureau of Canada, but this is not a major bone of contention.

COMPENSATION TABLES OF LA RÉGIE DE L'ASSURANCE AUTOMOBILE DU QUÉBEC FOR ACCIDENTS IN QUEBEC BETWEEN JANUARY 1 AND DECEMBER 31, 1986.

I Bodily Injury

A. Income Replacement Indemnities

Category	Compensation Amount[1]	
	Maximum	**Minimum**
1. Full-time workers	90% of net income[2]	$145.31 + $18.17 per dependant up to a maximum of $254.33 per week
2. Persons without full-time employment but able to work	90% of net income[2] derived from gross income established by La Régie	$145.31 + $18.17 per dependant up to a maximum of $254.33 per week
3. Persons at home (or may opt for compensation under category 2)	$272.45 per week for expenses incurred as result of the accident (e.g., home care, support)	
4. Persons unable to work for reasons other than age	$145.31 + $18.17 per dependant up to a maximum of $254.33 per week	Idem
5. Persons under 16. When they reach 18, if still unable to work	$145.31 per week $215.76 per week	Idem Idem
6. Students 16 or over enrolled in a secondary or post-secondary school full-time		

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[1] In the case of the income replacement indemnity, the pensions are decreased by the amounts of the disability pension and pension for children of disabled contributors payable under the Quebec Pension Plan or a similar plan outside Quebec. The pensions are also decreased by old-age pension amounts when beneficiaries reach the age of 65.

[2] The net income is established by subtracting from the gross income federal and provincial taxes, unemployment insurance contributions and Quebec Pension Plan contributions. The maximum gross income admissible is $33,000.

(a) With a well-paying job	90% or net income[2]	$145.31 per week
(b) Without a well-paying job	$145.31 per week	Idem
(c) For the delay actually caused in arriving on the job market	Annual amount of: • $11,250.39 for secondary students • $14,154.33 for post-secondary students minus what they make under (a) and (b)	
(d) Once studies are finished or stopped, if unable to work due to the accident	• $215.76 per week for secondary students • $271.45 for post-secondary students	Idem Idem
7. Persons age 65 or over	Idemnity based on the accident victim's situation at the time of the accident. Pension[1] based on the same criteria, according to whether the person falls under category 1, 2, 3, 4 or 6	

B. Other Indemnities

Category	Compensation Amount[1]	
	Maximum	Minimum
1. Lump sum indemnities for permanent bodily injury or disfigurement	$36,327.06	
2. Indemnities for the reimbursement of certain expenses incurred as a result of the accident (if they are not covered by another social security plan)	Reimbursement of expenses approved by La Régie upon presentation of appropriate supporting documents	
3. Rehabilitation indemnities	Payment for materials and services necessary for the accident victim's social and professional rehabilitation,	

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[1] In the case of the income replacement indemnity, the pensions are decreased by the amounts of the disability pension and pension for children of disabled contributors payable under the Quebec Pension Plan or a similar plan outside Quebec. The pensions are also decreased by old-age pension amounts when beneficiaries reach the age of 65.

[2] The net income is established by subtracting from the gross income federal and provincial taxes, unemployment insurance contributions and Quebec Pension Plan contributions. The maximum gross income admissible is $33,000.

in accordance with a rehabilitation program approved by La Régie

II Fatal Injuries

A. Pension-Type Death Benefits

Victims with Dependants[3]	Compensation Amount[1]
One dependant	55% of income replacement indemnity they would have been entitled to had they survived. Minimum: $145.31 per week
Two dependants	65% of this indemnity Minimum: $163.48 per week
Three dependants	70% Minimum: $181.65 per week
Four dependants	75% Minimum: $199.82 per week
Five dependants	80% Minimum: $217.99 per week
Six dependants	85% Minimum: $236.16 per week
Seven dependants	90% Minimum: $254.33 per week
Persons with no spouse or other dependant who ensured the viability of family business	Minimum: $145.31 per week for a maximum five-year period.

B. Lump Sum Death Benefits

Victims with Dependants[3]	Compensation Amount[4]
Persons with no spouse or other Dependant	$7,432.26 to parents of accident victim or $3,716.13 to the victim's estate
Funeral costs	$2,477.42

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[1] In the case of the income replacement indemnity, the pensions are decreased by the amounts of the disability pension and pension for children of disabled contributors payable under the Quebec Pension Plan or a similar plan outside Quebec. The pensions are also decreased by old-age pension amounts when beneficiaries reach the age of 65.

[3] For the purposes of the *Automobile Insurance Act*, the spouse is always considered the victim's dependant.

[4] In the case of pension-type benefits, the pension is decreased by the amount of the surviving spouse's pension and orphan's pension payable under the Quebec Pension Plan or a similar plan outside Quebec.

APPENDIX 13

EXCERPT FROM
CLAUDE FLUET AND PIERRE LEFEBVRE
"L'ASSURANCE AUTOMOBILE AU QUÉBEC: BILAN D'UNE RÉFORME"

February, 1986
pp. 1-22

Translated by
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Charlez Translation Limited

CHAPTER 1

Introduction

It is now seven years since automobile insurance reform was introduced in Quebec. To most observers, there is no doubt that the new protection, with respect to both bodily injury and property damage, is proving to be a marked improvement over the situation which existed prior to 1978. Nevertheless, no comprehensive evaluation is available regarding the results stemming from the measures introduced in 1978 and the changes contained in the *Automobile Insurance Act*. Of course, a number of sources, such as the Activity Reports and the Statistical Reports from the Régie de l'assurance automobile du Québec (the Quebec Government Automobile Insurance Board), the Reports on Automobile Insurance Rating in Quebec from the Inspector General of Financial Institutions or the Statistical Reports from the Insurance Bureau of Canada, are likely useful in judging the new plan and determining to what extent it has achieved its aims. However, these reports are, first and foremost, factual and only present certain quantified results connected to the field of automobile insurance. They are not inspired by the type of explicit analysis whose purpose would be to identify and follow the evolution of the net social benefits of the 1978 reform, the effects of which will necessarily be spread over time. Moreover, the 1978 reform went beyond the bounds of bodily injury. It consisted of introducing a system composed of two "sub-systems".

The most important of these was the Régie de l'assurance automobile, set up to deal with prevention and bodily injury; the other was to concern itself with all measures regarding property damage (direct compensation, compulsory third-party insurance, cancellation of subrogation, appraisal centres). It is clear, however, that these sub-systems are interdependent, the one acting upon the other.

A more in-depth and systematic analysis of the socio-economic impact of the 1978 reform can only improve the determinant information available regarding automobile insurance. The purpose of this study is to examine the reform and to clarify certain questions and proposals currently being discussed regarding automobile insurance. We have used a cost-efficiency assessment of automobile insurance from the beneficiary's point of view. In other words, we have tried to relate the level of protection granted and the cost of that protection. The study consists of three parts:

(i) an analysis of the development of the private market for automobile insurance with respect to property damage, in order to define the effects of the reform both on the automobile insurance industry and on the cost to the consumer of property damage insurance;

(ii) an evaluation of the achievements of the bodily injury compensation plan introduced in the 1978 reform, on the basis of the aims of that reform and our knowledge of the situation prior to the reform; and

(iii) lastly, a global evaluation of the reform, describing the evolution of the overall cost of the insurance in relation to changes in the levels of protection.

These points, in this order, are enlarged upon in chapters 3, 4 and 5 of the study. Chapter 6 provides a brief conclusion. Lastly, a summary of the principal results may be found in chapter 2.

CHAPTER 2

Chapter Contents, Summary and Conclusions

The Private Market in Automobile Insurance since 1978 (Chapter 3)

The *Automobile Insurance Act*, passed in 1977, assigned to a government board the administration of the new basic compensation plan for victims of bodily injury sustained in automobile accidents. As the compensation relative to bodily injury represented approximately one-third of all indemnities paid by private insurers prior to the reform, it was obviously anticipated that, after the Act took effect in March, 1978, it would mean a substantial reduction in sales for the private automobile insurance industry. This effect was to be somewhat mitigated by the fact that vehicle owners now had to insure themselves with private insurers for third-party liability for property damage. Prior to the reform, it was estimated that slightly less than 90% of vehicles were covered by a liability insurance contract. The 1977 Act also contained a number of additional provisions whose effect was to change automobile insurance practices and whose specific objective was to reduce the cost of settlement of automobile claims. This is notably the case where private insurers were obliged to adopt an agreement of direct compensation and to establish accredited appraisal centres for the appraisal of vehicles damaged in accidents.

Chapter 3 analyzes the effects of the 1977 Act on Quebec's private automobile insurance sector. This is done from two points of view — the effects on the industry alone and from the perspective of the insurance consumer. Section two of this chapter lists the chief provisions of the Act regarding the private practice of automobile insurance. Section three assesses the level of adjustment of the industry to the plan's reform. Section four examines the effects of the reform from the perspective of the insurance consumer with respect to compensation for property damages. Lastly, section five provides a brief synopsis and some general conclusions.

Summary and Conclusions

The analysis submitted in this chapter leads to the following conclusions or main findings:

1) The *Automobile Insurance Act* has had no appreciable impact on the number of practising automobile insurers in Quebec. There has been no change in the concentration level in this sector of activity — the market share of the five major groups of insurers remains approximately 35%. There has not been any significant change either in the market share of insurers having their head office or main office in Quebec. Such share is, as in the early 1970s, slightly more than 50% of subscribed premiums.

2) Since 1978, almost all passenger vehicles — an average of more than 96% depending on the year — have been insured for third-party liability in accordance with the requirements of the Act. This proportion was slightly lower than 90% prior to the reform. The proportion of vehicles with collision coverage has also risen (from 52% to 60%), as has the proportion of vehicles carrying comprehensive insurance (from 74% to 80%). This increase in the proportion of vehicles insured under various types of coverage has, to some extent, lessened the decrease in business in the private automobile insurance industry. The transfer of compensation for bodily injury to a public plan represented in itself an approximate loss of business of 31% (bodily injury made up almost half the costs and premiums of third-party liability). All else being equal, the increase in the proportion of passenger vehicles insured under various types of coverage has reduced the loss of business to approximately 23% of what the insurers would have collected had the reform not been implemented.

3) The years immediately following the reform (1978, 1979) were characterized by a slight rise in accident frequency, although this shouldn't really be seen as a simple cause-and-effect relationship, but rather as a result of a normal cycle in the insurance business. During this period, there was, however, a substantial increase in the frequency of claims made under third-party liability coverage. This increase was totally different from that observed with respect to collision coverage. The frequency of third-party liability claims rose to 12% in 1979-81, compared to an average of 9.6% over the 1973-78 period. However, there was no significant change in the frequency of claims under collision insurance (9.6% in 1979-81, as compared to 9.9% for the earlier period). It appears that this asymmetrical increase in accident claims must be attributed to the new rules introduced in the Direct Compensation Agreement and some of its provisions, notably the "amicable reporting" provision. This development has also resulted in compensation of a larger number of small claims, as opposed to what was previously the case. It is still too soon to say whether this shift in claims notification from collision to liability coverage will be a permanent phenomenon or whether the insurers and the insureds are simply going through an adjustment period (over the 1982-84 period, the frequency of liability claims fell back to its historical level).

4) Compensation for bodily injury is the principal reason for the increase, in real terms (i.e., aside from what could be expected due to inflation), of the cost of automobile insurance in Canada, excluding Quebec. For bodily injury, the average rated dollar cost per liability claim rose by 135% between 1978 and 1984, compared with an increase of 62% for property damage. This evolution is linked to the substantial increase, in real terms, of the settlements awarded by the courts under third-party liability proceedings. Conversely, in Quebec, the implementation of a plan to administer compensation for bodily injury resulted in control of the increase of costs and premiums (which characterized private automobile insurance), as compared with what was occurring elsewhere in Canada, even after the single adjustment (which was, of necessity, associated with this shift) had been eliminated. In other words, the Quebec government plan inherited that area of automobile insurance protection which experienced the most rapid cost increase elsewhere in Canada (in the provinces with private systems).

5) The years immediately following the reform (1979, 1980, 1981) were years of poor financial performance by the private automobile insurance industry in Quebec, as much at the level of underwriting losses as at the level of net industry profits — the combined result of a normal insurance cycle (these years being characterized by an increase in accident frequency) and the industry's adaptation to the loss of sales resulting from the reform. The cost of claims/underwritten premiums ratio went from 74.6% in 1973-78 to 98.2% in 1979-81, subsequently declining to 64.0% in 1982-84, giving an overall average of 81.1% for the 1979-84 period. The significant increase in this ratio during the sub-period 1979-81 is thus attributable to a "normal" increase in claims frequency and, in all likelihood as well, to the downward pressure on premium rates due to increased competition resulting from a temporary glut in the industry. The ratio increase for the overall period subsequent to 1978 is also attributable, to a lesser extent, to the rise in interest rates which altered the industry's financing structure, i.e., the premiums/investment income ratio.

6) However, for the overall period 1978-84, there was no significant drop in the profitability of private automobile insurance in Quebec. The return on equity in the industry was thus essentially the same over the six or seven years following the reform as over the six or seven years preceding it, i.e., an after-tax return rate of approximately 15% for the sample firms studied. However, in the absence of a structural disturbance such as occurred in 1978 and assuming that the level of competition characteristic of the industry remained constant, one would have expected an increase in the industry's return rate, due to the increase in interest rates, together with a "loss" of underwriting profits. This is what occurred elsewhere in Canada in the general insurance industry; the before-tax return rates went from approximately 7% to 10% from one sub-period to the other, at the same time as the underwriting experience was declining. In this sense, it seems appropriate to speak of a relative deterioration in the profitability of automobile insurance in Quebec (which now appears to move closer to the norm for Canada). It is

conceivable that this relative deterioration may be due to an increase in competition. Once again, it is too soon to judge whether this will be a permanent trend.

7) Total automobile insurance expenses may be expressed as the total of net claims paid to the insured plus the operating costs of the insurers (including claims settlement costs). In the middle term, the operating costs/total expenses ratio constitutes a yardstick of the system's efficiency or the "real" cost of insurance services. In the short term, as some costs do not vary proportionate to the indemnities actually paid, the ratio will depend on fluctuations in claims frequency. This ratio dropped slightly following the 1978 reform, from an average of 38% over the 1973-78 period to 34% over the 1979-84 period. This drop can be attributed only partially to the relative increase in claims frequency from 1979 to 1981. On the basis of a functional breakdown of operating costs into acquisition and marketing costs, underwriting and policy sales costs and, lastly, claims settlement costs, it appears that it is the decrease in the relative importance of the latter which made the greatest contribution to the drop in the operating costs/total expenses ratio (direct and indirect settlement costs, which accounted for 38.7% of the operating costs in 1974, dropped to 33.0% in 1979-80 and to 28.1% in 1981-84). It was impossible to verify to what extent this was due to the elimination of compensation for bodily injury or to a greater efficiency in dealing with property damage (further to the introduction of damage appraisal centres and the Direct Compensation Agreement). It could be noted that the phenomenon occurred despite the fact that a relatively larger number of small claims were now being compensated for both third-party liability as well as collision insurance (where the average deductible was significantly lower in real terms).

8) "Return to the insured" is usually defined by the net indemnities/premiums ratio. This ratio is commonly used as an indication of the benefit received by the insured in return for insurance premiums paid. This ratio went from 58% in 1973-78 to 67% in 1979-84 (i.e., 81% in 1979-80 and 60% in 1981-84). Similarly, the inverse ratio (i.e., premiums paid per dollar of net indemnity paid) measures the relative cost of the insurance to the insured. This cost went from 1.74 in 1973-78 to 1.50 in 1979-84 (i.e., a decrease of 14.8%). This relative cost could be expressed as the product of total expenses/net indemnities ratio by premiums/total expenses ratio. These two ratios fluctuate in the short term according to more or less predictable variations in accident frequency. To the extent that these fluctuations can be disregarded over the entire period of 1979-84 and the average ratios for the period thus be considered as representative of a complete cycle, the following conclusions may be drawn. As we saw in point 7, the first ratio is an indicator of the insurance industry's operating efficiency — the decrease in this ratio (due solely to an apparent increase in the efficiency of claims settlement) in itself accounts for 47% of the decrease in the relative cost of insurance. The second ratio (premiums/total expenses) is dependent on the financing structure of the insurers, i.e., the contribution of premiums in relation to investment income to the financing of their total expenses, and the industry's profit margins, or in other words on the amount of competition. The decrease in this second ratio accounts for 53% of the decrease in the relative cost of insurance. Keeping in mind the points outlined in 5 and 6, two factors come into play in explaining the decrease in this ratio. Firstly, the significant rise in interest rates at the beginning of the second sub-period resulted in an increase of the relative contribution of investment income as a source of financing (despite the reduction in settlement time limits). Secondly, due to an increase in competition resulting from perhaps only a temporary glut in the industry, the profit margins normalized in relation to what may be observed elsewhere in Canada. A rough breakdown attributes two-thirds of the decrease in the second ratio to the normalization of profit margins and the remaining one-third to changes in the financing structure. Consequently, in total, the decrease in the relative cost of insurance is due 47% to increased efficiency in claims settlement, 35% to the normalization of profit margins, and 18% to changes in the insurance financing structure.

The Government Automobile Insurance Plan since 1978 (Chapter 4)

The Government Insurance Plan introduced in 1978 deals exclusively with compensation for bodily injury (as opposed to property damage) resulting from traffic accidents. The administration of this plan was entrusted to the Régie de l'assurance automobile du Québec, a corporation under the meaning of the Civil Code, incorporated in 1977, with its first fiscal year commencing on March 1, 1978. Chapter 4 analyzes the public sector of automobile insurance in Quebec since the 1978 reform. As the amount of optional bodily injury insurance taken out through private insurers subsequent to that time is, for all practical purposes, negligible, almost the entire field of bodily injury insurance will be covered here. As much as possible, this chapter has been laid out in the same manner as Chapter 3. Section 2 of Chapter 4 describes the aims and basic features of the plan. Section 3 provides the principal statistics necessary for analysis of the evolution with respect to indemnities paid, operating costs and financing. Section 4 analyzes the plan's performance from the insured's perspective. Lastly, Section 5 summarizes the chapter and draws the chief conclusions from it.

Summary and Conclusion

The main conclusions to be drawn from this chapter are as follows:

1) The universal insurance plan introduced in 1978 and administered by the Régie de l'assurance automobile du Québec covers almost the entire field of bodily injury insurance in Quebec. Since 1978, this plan has received approximately 93% of the insurance premiums relating to this protection and has paid out approximately 97% of the net indemnities. The residual portion, supplied by the private sector, provides funds for bodily injury insurance under the third-party liability coverage for accidents occurring outside of Quebec and for the optional, supplementary insurance taken out by some individuals.

2) Taking into account all indemnity categories, over the last seven years, the Régie has paid out a yearly average of 54,000 new indemnities to 28,200 dead (their beneficiaries) or injured victims of traffic accidents. Almost 40% of the indemnities are paid out as pensions, either as death benefits or income replacement indemnities. Close to 60% are lump sum payments or compensation paid for reimbursement of medical, paramedical, or other expenses. During the period under study, approximately 36% of injured, but surviving, victims received income replacement indemnities for actual or assumed loss of income. Of the victims, 50% held full-time employment; 50% were not, voluntarily or otherwise, on the job market (minors, students, people at home, invalids, etc.). In all cases, the beneficiaries of the deceased received an indemnity for funeral expenses, i.e., 100%; approximately 36% received death benefits as a pension and 66% a lump sum payment (the latter two categories being mutually exclusive). The income replacement indemnities represented, on average, approximately 62% of the total value of indemnities paid (after deduction of related administrative expenses); death benefits made up 21% of this total and 17% related to other indemnities.

3) Separating the Régie's administrative expenses into those relating to the compensation plan and those relating to its other mandates is difficult. The net indemnities paid to victims of traffic accidents represent approximately 90% of the compensation plan's expenses *stricto sensu*, including related administrative expenses. These expenses represent approximately one-third of the Régie's total administrative costs; the remaining two-thirds apply to mandates other than insurance. Since the 1983-84 fiscal year, aside from promoting road safety as had been the case since the plan's introduction, these other mandates have included registration and issuing of licences, as well as administration of the *Highway Safety Act*. Aside from its registration and licence issuing activities (which are funded in large part by specific fees), the other mandates are financed by insurance contributions, either directly or through investment income from the stabilization reserve.

4) On an actuarial basis, the annual cost per fiscal year includes the actuarial cost of accident compensation for the fiscal year (including related administrative expenses) and the

cost of the Régie's other mandates. This cost is funded through insurance contributions, licensing fees, and investment income earned both on contributions and on the stabilization reserve. For the overall period 1979-84, indemnity costs generally tended to be over-estimated, resulting in frequent downward revision in actuarial liabilities and, consequently, the building up of a large stabilization reserve. This over-estimation was essentially due, especially in the plan's initial stages, to the reduction in the disability periods of victims compensated by the Régie, compared to the accumulated actuarial experience of the private insurers over the five years prior to the reform. The mid-term reserve for the 1983-84 fiscal year thus represented 78% of the insurance contributions received during the course of that year; this is clearly higher than the equity/premiums ratio of approximately 50% that is usually seen in the private general insurance industry. During the later years of the period under study, this cost over-estimation permitted financing of a growing portion of the cost of each fiscal year from the stabilization reserve, resulting in operating losses at the end of the period (before extraordinary items). At the beginning of the period, the projected financing was: insurance contributions — 95%, investment income — 5%; at the end of the period, it broke down as follows: contributions — 77%, investment income — 13%, reduction of the stabilization reserve — 10%. The actual financing at the end of this period was, however, 82%, 13% and 5% respectively for these three items. The reductions in the stabilization reserve were not, however, realized due to a downward revision in actuarial liabilities representing approximately 25% of the cost for the fiscal year.

5) A rough comparison between the current plan and the situation prior to the reform suggests that the proportion of traffic accident victims actually receiving compensation rose from approximately 41% to almost 50% — an increase of approximately 20% in the frequency of compensation. If analysis is limited solely to those who sustained serious injury, it may be concluded that almost all of these victims have been compensated. The time limits for settlement to compensated victims have been significantly reduced. While 65% had previously received no compensation six months after their accidents, this is only true of 4% of cases under the new plan. With adjustment of the compensation levels to correspond to the increase in the average earned income in Quebec, the indemnities per compensated victim rose approximately 14% with the reform. Taking into account the increase in the frequency of compensation, this translates as an indemnity increase of approximately 35% per accident victim. Lastly, the relative cost of insurance — total expenses (including related administrative costs) per dollar of net indemnity — has decreased significantly from approximately 1.63 to 1.13. The relative price of insurance decreased in more or less the same proportions.

6) Reduction in insurance administration costs is explained by the elimination of the concept of "fault" and by the regrouping of the various administrative activities within a single organization. This not only allows advantage to be taken of economies of scale, but also the elimination of some specific costs relating to competition, notably in the area of marketing. The regrouping into a single organization also facilitated certain related activities, such as the promotion of road safety and organization of efficient rehabilitation services.

A Global Evaluation of the Reform of 1978 (Chapter 5)

This chapter contains a comprehensive evaluation of the 1978 reform, taking into account both private insurance and the government plan, and deals as much with property damage as bodily injury. Section 2 describes the evolution of the structure of automobile insurance in Quebec, based on premiums, compensation and costs, as well as a public/private and bodily/property breakdown. To put things into perspective, the evolution of variables in constant dollars will also be described. Section 3 deals with the development of the common efficiency indicators, allowing a global evaluation of profits attributable to the reform to be covered in Section 4. Section 5 reviews a number of questions to do with insurance financing and premium evolution while taking profits and taxation into consideration. Lastly, Section 6 compares the government plan in Quebec with the private system in force in Ontario and the government systems in the western provinces.

Summary and Conclusion

Confining ourselves to basics, the implications of the 1978 reform of the automobile insurance plan in Quebec, as it pertains to both bodily injury and property damage insurance, may be summarized as follows:

1) The structure of the automobile insurance system has been drastically altered. Based on actuarial evaluations made one year after the end of each accident year, approximately 97% of the net indemnities paid as compensation for bodily injury are now paid by the public plan introduced in 1978. Moreover, based on these same evaluations, bodily injury indemnities now account for approximately 39% of the total net automobile insurance indemnities, compared to 35% prior to the reform.

2) The average level of bodily insurance indemnity per compensated victim rose substantially in constant dollars (by almost 35%), as did the frequency of compensation of traffic accident victims (by 18%). This same phenomenon is noted to a lesser degree with respect to property damage insurance, due to an increase in the number of insured vehicles and a broadening of vehicular insurance coverage (reduction in the real level of the deductible and a larger number of optional insurance coverages).

3) The anticipated efficiency gain related to the introduction of a public plan for bodily injury insurance and the rule changes with respect to private insurance for property damage (Direct Compensation Agreement, etc.) had actually been realized. From the sub-period 1973-77 to the sub-period 1978-84, the total expenses/net indemnities ratio declined 4% with respect to property damage and 36% with respect to bodily injury insurance — a total reduction of 15%.

4) The average premiums or contributions of blanket coverage per vehicle actually insured for third-party liability in Quebec have risen, in real terms, between 1973-77 and 1978-84. The average premium rose by 1.5% for bodily injury insurance and by 9.6% for property damage insurance — an average total increase of 6.7% per insured vehicle. The premium increase factors for both types of coverage are: the increase in the real level of indemnities per victim or compensated claim, and the increase in the frequency of compensation. There is also a slight increase in the frequency of property damage accidents. These increase factors are offset to a large extent, however, by the increase in return to the insured (efficiency gain and changes in the method of financing) and by a broadening of the premium collection base (increase in the number of vehicles contributing to insurance financing in relation to the overall number of vehicles on the road). It may be observed that part of the increase in return to the insured for bodily injury results from the elimination of certain taxes or levies and is thus borne by the taxpayers in general.

5) A rough comparison with the features of the private insurance system in force in Ontario suggests that the insurance structure in Ontario puts greater emphasis on bodily injury. For the 1978-84 period, the gross bodily injury indemnities/total gross indemnities ratio was 43% in Ontario, compared to a net indemnities ratio of 39% in Quebec (for 1982-84, the ratio in Ontario rose to 50%). This appears to be accounted for by the extremely high level of average indemnity per bodily injury claim (for third-party liability) in Ontario following judgments awarded by the courts over the past few years. However, it must be kept in mind that we are dealing here with gross indemnities which include the insurers' settlement expenses and, particularly, the litigation expenses borne by the insured. The return to the insured is much higher in Quebec than in Ontario, due solely, however, to the government bodily injury insurance plan. The return to the insured in Quebec is roughly the same (although slightly better) as that seen in the government systems in Canada's western provinces.

Conclusion (Chapter 6)

With respect to compensation for both property damage and bodily injury (in a more marked fashion, obviously, in the latter instance), evaluation of the reform appears quite positive: overall protection increased; an appreciable efficiency gain resulted in reduction of the relative costs of insurance; the more qualitative aspects of the compensation procedure also underwent definite improvement. The reform of 1978 had taken a stand on certain basic issues which were, and still are, relatively controversial in the public mind. Three basic choices may be identified in this respect: elimination of the concept of "fault" and the right to recourse; lump sum compensation on the basis of predetermined scales for non-monetary losses; administration of the plan by a public board. These three basic choices appear, in retrospect, to be justified.

APPENDIX 14

THE AMERICAN EXPERIENCE WITH NO-FAULT AUTOMOBILE INSURANCE WITH SPECIAL REFERENCE TO THE MICHIGAN SYSTEM

In the United States, the Department of Transportation (DOT) recently completed a Follow-Up Report on No-Fault Auto Insurance Experiences entitled "Compensatory Auto Accident Victims" (May 1985). This is an extremely useful study which provides a great deal of insight into the performance of the variety of no-fault systems that now exist in the United States. More importantly, it sets out the key criteria which should justify a fundamental shift to no-fault insurance in Ontario at least in respect of automobile insurance, and perhaps also in respect of all accidental injury.

The following discussion will set out the performance criteria and the conclusions drawn from the DOT study. Then, the Michigan system of no-fault automobile insurance combined with a very high verbal threshold will be examined in greater detail.

The DOT study examined two types of no-fault auto insurance: no-lawsuit no-fault, and add-on no-fault. These were defined as follows:

> No-lawsuit is the form of no-fault under which a motor vehicle accident victim can always receive no-fault benefits but cannot always bring a lawsuit against the person whose fault caused the accident and injury, on the ground that lawsuits are unnecessary in some cases, where victims have a right to no-fault benefits. The term "no-lawsuit" is not totally accurate because each of the States that today restricts lawsuits by recipients of no-fault benefits does allow some such lawsuits under certain circumstances. The term is nevertheless appropriate because it emphasizes the primary distinguishing feature of this category: lawsuit restriction in exchange for assured no-fault benefits.
>
> Add-on is the particular form of no-fault that does not restrict a victim's right to bring a lawsuit against any other person believed to be at fault, while at the same time providing assured no-fault benefits to that victim. Under add-on auto insurance, lawsuits and no-fault benefits are both always allowed. In the States that have this kind of auto insurance, the right to recover no-fault benefits is always a supplement to, rather than a substitute for, the traditional right to sue the wrongdoer. (pp. 1-2)

In considering the most appropriate no-fault scheme, the central issue is the question of balance. This "refers generally to the trade-off between the savings from restrictions on lawsuits and the added costs of providing new no-fault benefits. More specifically, to have 'balance' in a no-lawsuit system, the system must have effective restrictions on lawsuits such that the savings generated by limiting lawsuits and thus constraining third-party damages will 'pay for' the cost of first-party benefits. To have balance in an 'add-on' system, where there are no restrictions on lawsuits, the average amount of the third-party payments must be lower than the average amount of third-party payments in traditional States by such an amount that the 'savings' will equal the cost of first-party no-fault payments" (p. 3).

The following general conclusions were drawn by the DOT study based on over 12 years of experience in 24 jurisdictions, and are worth reproducing in detail:

1. Significantly more motor vehicle accident victims receive auto insurance compensation in no-fault states than in other states. Almost twice as many victims per hundred insured cars receive PIP benefits in no-fault states as receive BI liability payments in traditional states.
2. In general, accident victims in no-fault states have access to a greater amount from auto insurance than victims in traditional states.

3. Although no-fault states, on average, have higher total insurance premiums than traditional states, this seems to be due to the inclusion in the average of no-fault states with laws that are out of balance. From 1976 to 1983, the average auto insurance premium in the average traditional state rose 50%. During the same period, the average auto insurance premium rose (a) 54% in the average no-fault state with a law that is in balance, and (b) 126% in the average no-fault state with a law that is not in balance.
4. "Balance" in no-fault systems seems to be closely linked to the presence of an exclusively verbal or a high medical expense dollar threshold. In fact, the appropriateness of the threshold is likely to be the principal factor in determining whether a system is in balance. (Note that all of the states which permit recovery of third-party benefits only upon satisfaction of a verbal threshold are in balance. Michigan is the outstanding example.)
5. Compensation payments under no-fault insurance are made far more swiftly than under traditional automobile insurance.
6. No-fault insurance systems pay a greater percentage of premium income to injured claimants than do traditional liability. One of the highest rates, 55.1 cents of each personal injury premium dollar, was reached by the state of Michigan, the state which provides the greatest amount of no-fault benefits to accident victims and which puts the strongest restrictions on lawsuits and third-party benefit recoveries.
7. State auto insurance laws which provide high no-fault benefits would appear to better facilitate the rehabilitation of seriously injured motor vehicle accident victims than traditional laws, although the lack of good data on rehabilitation experience under traditional laws precludes a good quantitative estimate of the difference.
8. No-fault has led to reductions in the number of lawsuits and, thus, to significant savings in court and other public legal costs paid by the taxpayer. According to Chief Justice Warren Burger, each jury trial tort case costs the taxpayer approximately $8,300 in court and other public costs, while the precise level of savings entities is substantial.
9. Typical auto insurance benefits in both no-fault and traditional states fall short of the needs of catastrophically injured victims. Only the no-fault laws in Michigan and New Jersey, which provide for unlimited medical benefits, meet the medical needs of all victims of catastrophic injury.
10. The percentage by which the cost of payments to accident victims in no-fault states exceeds the cost of such payments in traditional auto insurance states has increased from 1976 to 1983. This suggests that it is necessary to consider new ways to reduce costs, such as repealing the collateral source rule and/or putting a ceiling on pain and suffering damages that an accident victim can receive if that victim was also eligible to receive no-fault benefits.
11. No-fault automobile insurance laws do not lead to more accidents.

The foregoing points and the detailed back-up statistical analysis clearly reveal the advantages of a well-balanced no-fault system, preferably with a verbal threshold to limit lawsuits, over the traditional auto insurance system. It is important to note, as well, certain key features of the no-fault no-lawsuit system before turning to a specific analysis of the Michigan example. These are as follows:

- Most no-fault no-lawsuit states have concluded that the no-fault insurance should be compulsory rather than voluntary, and that this should be coupled with compulsory personal injury liability insurance. (Note that Ontario has had compulsory automobile insurance since 1979.)
- Some no-fault no-lawsuit states also require the purchase of uninsured motorists' insurance and/or require it to be offered or issued to all policyholders. This bears no

direct relationship to no-fault insurance. Rather, the requirements reflect a contest between those who supported a total change to no-fault compensation and those who supported only an improvement to or cure for the imperfections of the traditional tort-based liability insurance system. (Note that Ontario insurers provide such coverage.)

- Only Michigan has opted for no-fault property insurance in addition to no-fault personal injury insurance. However, millions of Americans purchase automobile collision insurance and automobile comprehensive insurance as traditional forms of first-party property insurance.
- Most no-fault states give the policyholder the option of purchasing PIP coverage with a deductible. The effect of the deductible is to enable the motorist with health insurance or other assets to do without automobile insurance benefits to the extent of that deductible, and thereby pay a low auto premium.
- No jurisdiction provides no-fault benefits for pain and suffering damages or non-pecuniary losses.

Having now set out the key features of any no-fault, no-lawsuit automobile insurance plan, it is useful now to turn to the specific Michigan experience. The reason for this focus is that it appears that the Michigan system is superior to all the other American examples in terms of the five criteria by which the effectiveness of the system should be judged: (i) its cost in terms of average premiums; (ii) its benefits to injured automobile accident victims; (iii) the speed with which it pays those benefits; (iv) the percentage of the money collected as premiums which it pays to accident victims as benefits; and (v) the extent to which the system is in balance or not in balance.

To begin with, the Michigan system is succinctly summarized as follows (p. 34):

MICHIGAN

Mich. Comp. Laws Ann. $500.3101, effective 10/01/73

MAXIMUM PIP BENEFITS

Medical and rehabilitation expenses	Unlimited
Wage loss (85% for 3 years @ $1,475 per month)	$53,100
Replacement services loss (3 years @ $20 per day)	21,900
Survivors' loss ($1,475 per month for 3 years)	53,100
Funeral expenses	1,000
Total per victim:	Unlimited

THRESHOLD FOR LAWSUIT IN TORT

Monetary: None.
Verbal: Death, serious impairment of a bodily function, or permanent serious disfigurement.

OTHER IMPORTANT PIP (NO-FAULT) PROVISIONS

- Penalty for late payment of PIP benefits.
- No excess PIP insurance need be offered by insurers.
- Deductible of $300 per accident required to be offered.
- Deductible and exclusion "reasonably related to other health and accident coverage on the insured" required to be offered.
- PIP benefits are primary, except that policyholder can designate his or her health insurer as the primary provider of medical benefits resulting from an auto accident.
- Co-ordination of PIP with health insurance required.

GENERAL INSURANCE PROVISIONS

- PIP compulsory, except as to motorcycles and mopeds.
- BI liability compulsory with $20,000/$40,000 limits.
- Uninsured motorists: no provision in law.
- Underinsured motorists not required to be offered coverage.

1983 PERFORMANCE DATA

	PIP	BI
• Average premium:	$63	$55
• Percentage of Total PI Premium:	53.49%	46.6%
• Paid Claims, Number:	39,850	9,507
• Paid Claims, Total Amount:	$168.5 million	$117.98 million
• Paid Claims, Average Amount:	$4,230	$12,410
• Paid Claim Frequency:	1.23	0.29

• Payout/Pay-in Ratio:	55.1%
• Average Total Limits Premium:	$153.72

Overall Change in Injury Insurance Costs as a Result of No-Fault: −17%.

A few observations on several aspects of the Michigan plan are useful. First, the Michigan no-fault law comes closest to a complete no-lawsuit, no-fault law. The law eliminates the right to tort action for losses resulting from bodily injury in automobile accidents, except in cases where economic losses exceed the benefits provided by no-fault insurance, or when non-economic losses exceed a pre-defined threshold. The threshold above which tort action is still permitted to recover non-economic losses is defined as follows:

> A person remains subject to tort liability for non-economic loss caused by his ownership, maintenance or use of a motor vehicle only if the injured person has suffered death, serious impairment of bodily function, or permanent, serious disfigurement.

In other words, the threshold requires significant bodily impairment before permitting the right to sue. Permanent disability and scarring qualify, but lesser injuries (such as minor whiplash or hairline fractures where there is complete recovery at an early date) do not. In practice, however, some types of minor injuries have been compensated, even if they were not permanent, because the words "serious impairment of bodily function" have been liberally interpreted.

Tort action is also permitted if an injury was caused intentionally or if economic losses exceed the limitations of the benefits paid under no-fault.

Despite the substantial foreclosure of tort actions, however, it is interesting to note that State Farm Mutual Insurance Company has estimated that the average premium cost in 1983 for bodily injury liability (BI) coverage was $55.00 — almost the same as its average cost for personal injury protection (PIP) coverage of $63.00. Thus if all lawsuits were prohibited in Michigan (as in Quebec today), the average motorist would theoretically save $55 on the cost of his or her car insurance — a reduction of almost 50% of the personal injury premium, although the actual savings would be less since insurers would increase the current PIP premium.

As the DOT study notes, as a result of the high verbal threshold, Michigan definitely experienced a significant decline in the number of automobile negligence cases filed in its circuit courts in the years after 1973 (the year no-fault went into effect).

> According to a report prepared by the Michigan Insurance Bureau in 1978, the number of lawsuits remained relatively constant in 1974 and 1975, probably because the statute of limitations had not expired on pre-existing claims, but from July 1975 until June 1977 the number of lawsuits filed declined by approximately 31.3%. The Michigan Insurance Bureau also measured lawsuit potential indirectly by calculating the amount of the liability and residual liability claims paid by the six largest insurers in Michigan before and after no-fault became effective. The amount of money paid on liability claims by these insurers in the first year after accidents declined from about $20 million annually in each of the three years before no-fault took effect to about $1.5 to $2 million annually in each of the three years after no-fault. For accidents occurring the year before no-fault became effective in Michigan, paid liability claims totalled $46.1 million over the period extending from the time of the accident over the next 39 months; accidents occurring the year no-fault became effective resulted in paid liability claims of $14.2 million over the same period. (p. 114)

A second important observation is that Michigan's no-fault system provides for unlimited medical benefits including substantial vocational rehabilitation benefits. And, in a recent ruling by the Attorney General in 1983, it was held that the Michigan law includes "all reasonable charges for reasonably necessary products and services to restore an injured person to a condition of physical health, as well as useful and constructive activity within the limits of his or her physical disability through vocational or occupational retraining, if necessary and reasonable".

The Insurance Bureau of Michigan made the following observations with respect to the value of rehabilitation in its 1978 review of no-fault auto insurance (p. 110):

> Recent estimates have shown that for every dollar spent on rehabilitation, $9 are returned through increased productivity, and that for every rehabilitated spinal cord injury, $60,000 in future medical and nursing home costs are saved. However, a successful rehabilitation is generally possible only if an individual gets appropriate treatment as soon after the accident as possible. Placing a ceiling on PIP payments will serve to introduce uncertainty for the injured individual on whether or not he or she can afford rehabilitation treatments. This uncertainty inevitably causes delay and markedly reduces the possibility of successful rehabilitation.

And in 1982, a report by the All-Industry Research Advisory Council confirmed the Michigan estimates and the 1980 AIRAC findings as to the cost-benefit efficacy of rehabilitation in auto accident injury cases. This study provides continuing evidence that "physical rehabilitation procedures improve the functional independence of severely injured persons".[1]

One particular objection to unlimited rehabilitation and medical benefits raised by insurers is that it imposes an excessive and unfair burden on small insurance companies that happen to have insured a person who suffers a catastrophic injury. To overcome this problem, a special statute was passed that created an unincorporated, non-profit association to be known as the Catastrophic Claims Association. The DOT Study described the association as follows (p. 126):

> The Catastrophic Claims Association of Michigan is directed to indemnify Michigan's auto insurers, all of which are required to be members of the Association, for all losses under PIP claims in which the total loss is expected to exceed $250,000 and to "calculate and charge to members of the association a total premium sufficient to cover the expected losses and expenses of the association" according to a statutory formula.

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[1] AIRAC, Insurer Study of PIP Serious Injury Claims: Second Follow-Up (1982) (p. 26).

According to the November 1983 report of the Chairman of the Board of the Michigan Catastrophic Claims Association, the Board has approved a $5.91 assessment per insured car to pay for the cost of indemnifying all companies for all medical expenses paid over $250,000 per victim during the period from January 1 to December 31, 1984. Footnote 1 to the report indicates that the per-car assessment for all but the first year of the Association has been about the same, despite inflation in medical costs and despite increases in Michigan automobile insurance premiums. The smallness of the rate ($6 per policy) and the lack of change in the rate of assessment over time suggest that paying unlimited medical and rehabilitation expenses via a catastrophic injury fund may be practicable.

From July 1, 1978, until June 30, 1983, 933 catastrophic claims cases were reported to the Michigan Catastrophic Claims Association (MCCA). Of this total, 550 (58.9%) involved brain injuries, 134 (14.4%) involved quadriplegia, and 129 (13.8%) involved paraplegia. Of the 933 victims, 662 (70.9%) were male. At the time of the accident, 406 of the victims (43.5%) were driving an automobile, 169 (18.1%) were pedestrians, and 64 (6.9%) were on a motorcycle that collided with an automobile.

After commenting on the AIRAC study of a group of catastrophically injured auto accident victims, the DOT Study has concluded that in the absence of high benefits, no-fault automobile insurance, it seems highly unlikely that there would have been sufficient resources available to treat these catastrophically injured victims and to provide for them the rehabilitation programs necessary to produce any significant improvement in their condition. The traditional system does not provide compensation for victims beyond the limits of the liability insurance policy of an involved driver, and the normal liability policy is totally inadequate to pay the high costs of the care which the most severely injured typically require. Therefore, most of the cost of care for most of the catastrophically injured may have to be borne by the taxpayer, in the form of public assistance.

Two other objections of insurers to unlimited medical and rehabilitation benefits should be noted. These relate to the difficulty in assessing the potential exposure, and the overutilization of medical benefits by some physicians and other health-care providers. In this connection, State Farm has suggested the creation of medical peer review groups to which insurers could submit questionable medical bills. Another possibility would be mandatory arbitration of disputed medical bills.

A third observation about the Michigan system pertains to no-fault property damage insurance. As noted above, Michigan alone prohibits lawsuits based on fault for automobile property damage in return for eligibility for first-party (no-fault) insurance. The law, however, is complex. It makes each Michigan motorist immune from being sued for property damage in excess of $400 but it does not require the motorist to buy no-fault property damage insurance. The motorist can sue for vehicle damage up to $400 where the amount is not payable by insurance, and can elect one of the following five options:

1. The motorist may choose to buy no collision insurance at all. Under this option the motorist in effect foregoes the ability to recover any compensation for property damages losses above $400.
2. The motorist may choose to buy "limited collision" insurance with a deductible, which means that the motorist collects nothing if at fault, and the cost of vehicle repairs less the deductible if not at fault.
3. The motorist may choose to buy "limited collision" insurance without a deductible, which means that the motorist collects nothing if at fault, and the full cost of repairs if not at fault.
4. The motorist may choose to buy "regular collision" insurance, which means that

> the motorist collects the cost of repairing his or her own car, less a deductible, regardless of fault.
>
> 5. The motorist may choose to buy "broadened collision" insurance, which means that the motorist collects the full cost of repairs if not at fault, and the full costs of repairs less a deductible if at fault. (p. 135)

In recent years, the Michigan Insurance Bureau has had to put a great deal of effort into helping motorists to understand the law. And it now appears that, as of 1984, the number of complaints about the system has declined significantly.

One final observation: The Michigan no-fault no-lawsuit law, like all state laws limiting the victim's right to sue in return for no-fault benefits, has been upheld as constitutional. All courts have held that laws which deprive auto accident victims of a right to sue persons allegedly at fault are constitutional, provided they also guarantee that the victims receive benefits for at least some of their economic losses. It is equally constitutional to deprive the victim of the possibility of receiving both "pain and suffering" *and* economic loss damages if that victim is guaranteed the recovery of economic loss damages. The Supreme Court of Michigan has specifically held that no-fault insurance is constitutional because it "bears a reasonable relationship to a permissible legislative objective" and has a "rational basis". (*Shavers v. Kelly*, 267 N.W. 2d 72(1978).)

It would be appropriate to conclude this description of the Michigan system with the following comments of Michael LaMonica, the actuary with Allstate Insurance Company in Northbrook, Illinois. In a special submission to the Task Force, he summarizes why the Michigan system, as opposed to those in force in other American states, is a very cost-effective way to increase the return of the premium dollar to victims of personal injury:

> Of those states with restrictions on bringing suit, Michigan has the strongest threshold, commonly referred to as a "verbal threshold". Non-economic losses are recoverable only if injury results in death, serious impairment of bodily function, or permanent serious disfigurement; economic loss recovery is prohibited to the extent of first-party benefits received. This latter restriction is quite strong since Michigan has a very high level of first-party benefits. Medical benefits are unlimited and benefits are provided for 85% of wages lost up to $2,434 per month for three years.
>
> The cost savings on bodily injury liability in Michigan from the verbal threshold is about 50% as compared to pure tort. This savings has stayed relatively consistent since the inception of the law. New York and Florida also have verbal thresholds with savings of about 40%. This lower amount is due to the thresholds being somewhat weaker and to lower first-party benefits in these states. The cost savings in states with dollar thresholds (i.e., dollars of medical expense that must be incurred) show lower levels of savings, and in addition these savings have become less over time. This decrease in savings is due to the "target" created by the dollar threshold as well as inflationary erosion. Examples include New Jersey, where the initial savings on the $200 threshold was about 25% but has since deteriorated to about 15%; and Pennsylvania, where inital savings of 25% for a $750 threshold was down to less than 20% before its repeal in 1984. Other dollar threshold systems demonstrate savings of only 15% to 30%.
>
> In summary, then, a verbal threshold similar to that in Michigan provides the largest savings on bodily injury costs. Dollar thresholds have shown a smaller degree of savings and the savings have deteriorated over time.
>
> The increases in Michigan bodily injury premiums since no-fault have overall been comparable to bodily injury premium increases in tort states. Again, though, Michigan bodily injury premiums are about 50% less than what they would be in a pure tort system.

Another cost-saving feature of the Michigan law is the use of co-ordination of benefits: reduced first-party premiums are afforded where it can be demonstrated that the insured has other coverage, such as group health benefits, which are designated to be primary to the auto coverage. A large proportion of insureds utilize these options, saving 25% of first-party benefit premiums.

APPENDIX 15

THE NEW ZEALAND UNIVERSAL ACCIDENT COMPENSATION SYSTEM

Many observers have noted that, in principle and in theory, it does not make sense to distinguish between victims of automobile accidents and victims of other types of accidents. Thus if, with a view to furthering the public interest in an equitable personal injury compensation system, we shift to a no-fault basis for the compensation of automobile-related injuries, it might seem only logical and equitable to go further and implement a no-fault scheme for all accidental injury.

New Zealand alone has been the pioneer in recognizing the foregoing logic with the implementation of its accident compensation scheme in 1974. A brief description and assessment of the New Zealand model would be valuable.[1]

The central concept in the accident compensation scheme is "personal injury or death *by accident*". This concept acts as a procedural bar to any common law action for damages and as an eligibility criterion for the payment of benefits under the *Accident Compensation Act 1982*. The common law action for damages for personal injury and the reception of statutory benefits are mutually exclusive concepts.

For those suffering injury or death by accident the coverage is comprehensive. With minimal exceptions it is of no concern where, how, when or why the personal injury or death by accident occurred. The victims of road accidents, work accidents, boating accidents, school accidents, hospital accidents — indeed accidents of any kind — are covered twenty-four hours a day. The only exceptions are those whose injuries are self-inflicted and those who have been injured as a result of criminal activities for which they have been convicted and imprisoned.

The centrepiece of the accident compensation scheme is income replacement known as earnings related compensation (ERC). As a general principle ERC is available to all earners, both employees and the self-employed, who are able to show that their injuries prevented them from earning to pre-accident levels. During the first week the employer pays 80% of income loss. After the first week the Accident Compensation Corporation pays 80% of lost earning capacity to all earners. ERC is subject to an upper maximum which includes 97% of New Zealand incomes. Provision is made for a permanent pension for the permanently disabled. The buying power of ERC is maintained with reference to increases in the New Zealand weekly average wage. Benefits are also paid to cover medical or dental costs not covered by the social security system.

The Act also covers the cost of future care, expenses directly resulting from the injury, loss of service of a domestic and household nature, and the cost of rehabilitation aids and training. Finally, the accident compensation scheme continues to award moderate lump sums for non-pecuniary loss. A lump sum not exceeding $17,000 is payable for permanent loss or impairment of bodily function arising from the injury. The award is made on the basis of a schedule of physical impairment. In addition, a maximum sum of $10,000 may be awarded for loss of amenities or capacity for enjoying life, and pain and suffering. Assessment is subjective and the loss must be of a sufficient degree to justify a payment. The assessment of the lump sum awards is made as soon as the medical condition has stabilized and no later than two years from the date of the accident. Clearly those lump sums play a subsidiary role and the crux of the scheme is compensation for pecuniary loss: both loss of income and the costs of future personal care.

In the case of a fatal accident, both ERC and moderate lump sums are payable to dependants. A totally dependent spouse receives ERC in the amount of three-fifths of the total that would have been payable to the deceased if he had survived with total loss of earning capacity. A partially dependent spouse is paid a proportionately reduced benefit. Payments continue so long as the condition of dependency lasts or until age 65. Dependent children are paid one-fifth of the amount that would have been payable to the deceased if he had survived with total loss of earning capacity. The total amount of ERC cannot exceed the maximum payable to the deceased if he had survived. Lump sums are payable in the amount of $4,000 to a totally dependent spouse and $2,000 to each dependent child. Reasonable funeral expenses are also covered.

There is a four-tiered system of review and appeal which includes an informal re-examination by the Accident Compensation Corporation, a formal hearing by a Review Officer of the Corporation, a further appeal to the independent Accident Compensation Appeal Authority and final appeal to the courts.

The Corporation is also charged under the Act to play an important role in rehabilitation and accident prevention and safety.

With respect to the financing of the scheme, it is funded predominantly by levies on employers, the self-employed and the owners of motor vehicles. The scheme for the first ten years was financed on a fully funded basis and during that time levies on the self-employed and employers were approximately 1% of leviable income and 15% of leviable payroll respectively and the annual levy on the owners of private automobiles was $14 to $20. In 1984 the basis of funding was changed to a modified pay-as-you-go system. Levy rates are set to provide sufficient reserves for the payment of approximately five years of entitlements. In 1985–1986 levy rates for employers dropped to 0.71% of leviable payroll. For the self-employed it continues to be 1.00% of leviable income. Levies on the owners of private automobiles rose to $21.55.

Overall, one can conclude that the money flowing through the workers' compensation system and the automobile fault/insurance system was sufficient to finance the no-fault scheme and that the scheme is almost certainly cheaper than a continuation of the old system. It was estimated in 1982 that the accident compensation scheme resulted in annual savings of over $100 for the owners of private motor vehicles. Similar results have been predicted in Australia and the United Kingdom. It has been claimed that a similar scheme in Australia would save the country $1 million per day[2] and the Pearson Commission found that a move to no-fault would result in an annual saving of 84 million pounds.[3]

The lessons to be learned from the New Zealand experience, both positive and negative, have been succinctly analyzed by Professor Osborne. They are as follows:

(1) **Comprehensive Entitlement**
There is a significant advantage in a scheme which provides comprehensive entitlement for all accident victims in society. Neither eligibility for compensation nor the level of benefits depends upon the class of person, the category of accident or the manner in which the accident occurred. Public uncertainty and confusion are reduced substantially when all accident victims are treated alike.

(2) **Administrative Efficiency**
The accident compensation scheme in New Zealand is administered by one institution — the Accident Compensation Corporation. This avoids the waste and confusion engendered by the current Ontario system where a disparate array of accident compensation vehicles all have their separate administrative structures. It also avoids the inordinate amount of time spent defining the parameters of each plan and resolving consequent questions of eligibility, set-off and subrogation rights among them.

(3) **Speedy Claims Processing**
The scheme adequately addresses the major concern of speedy, predictable and certain income replacement. Payments to injured persons commence after an average delay of only ten days.[4]

(4) Low Administrative Costs

Compared to the fault/insurance system the administrative cost of the no-fault scheme is minimal. In New Zealand the percentage of administrative costs to total income in the year ending March 1985 was 8.4%, compared with 7% and 8.5% in the preceding two years. This should come as no surprise since Workers' Compensation, Unemployment Insurance and Canada Pension Plan in Canada operate on an administrative cost of less than 10% of total benefits. In 1984 the Accident Compensation Corporation employed 682 employees to process 159,106 claims and to carry out the Corporation's rehabilitation and accident prevention functions.[5]

(5) Eligibility Criteria

There is much greater certainty and predictability in respect of eligibility. In the year ending March 31, 1984, only 0.65% of all claims were rejected by the Corporation, and in the following year the figure was 0.79%. Thus the general concept of "accident" appears to be well understood by the public and creates little practical difficulty.[6]

(6) Reduction in Litigation

The no-fault system has proved to be a relatively non-litigious compensation system. In 1984 the Corporation handled 159,106 claims. There were 5,896 applications for a Review Hearing, of which 3,505 went to a full hearing. Thus only 3.7% of claims went to a hearing (1.7% in 1983). There were 294 appeals lodged with the Accident Compensation Appeal Authority. This figure is 0.18% of claims handled during the year.[7]

(7) Deterrence

New Zealand provides no demonstrable evidence on the deterrent function of tort law either way. Since accidents are no longer analyzed on the basis of fault there are no statistics on whether there has been an increase in negligent conduct. Claims have increased steadily year by year but they have been mainly in the area of sporting accidents and home accidents, where the tort would have less impact. In the area of work accidents, where one might have expected evidence of the loss of the deterrent impact of tort law, claims fell from 46,900 in 1980 to 44,269 in 1982. Claims may also have risen as a result of greater public awareness of the scheme and because society is getting more dangerous but not necessarily more negligent.

There has been some concern about an increase in defective products. However, New Zealand's product safety regulations are not as stringent as those in Canada and steps are being taken in New Zealand to tighten safety regulations in regard to products.

Overall, it seems fair to conclude that the absence of the fault/insurance mechanism did not have any fundamental impact on the extent of careless conduct in New Zealand. (See also Craig Brown and Elizabeth Cummins Seto article.)

(8) Lump Sum

It was probably a mistake to retain lump sum payments for loss of enjoyment of life, and pain and suffering. The assessment of these claims is subjective, individualized and meagre (maximum of $10,000). It is productive of many hearings and appeals, a significant proportion of which involve legal representation. It causes dissatisfaction in respect of the low level of benefits. It would clearly have been better to incorporate the $10,000 into the $17,000 maximum for the scheduled payment for loss of bodily function.

(9) Administrative Style

There is little doubt that the Accident Compensation Corporation processes the great bulk of clear-cut accident claims in a speedy, simple and straightforward manner. However, there is reason for concern in respect of the handling of claims that are less clear-cut — the line-call cases. Margaret Vennell has commented:[8]

> In simple cases compensation payments are made comparatively rapidly but once the facts of a claim involve any difficult questions the establishment of the right to compensation becomes difficult and protracted. . . . The Woodhouse Commission envisaged a speedy inquisitorial process, but in complex cases the adversary process of the common law has been replaced by an adversary process between the Accident Compensation Corporation and the victim.

The reasons for this rigid, legalistic and strict administrative style are not clear. Initially there may have been an understandable uncertainty and apprehension of the plateau cost and financial viability of such an untried scheme. This initial caution may have become institutionally entrenched. There has also been government pressure to contain the cost of the scheme. Much of the responsibility must lie with the senior administrators of the scheme, who appear to have regarded cost-cutting as a priority beyond all others. Some responsibility must lie with the legislation, which entrusted to the Corporation a high degree of discretion in decision-making. Discretion can be exercised conservatively just as easily as liberally. Some criticism must rest with the personnel in the Corporation, many of whom carried with them attitudes developed in the insurance industry whence they came. Finally, there are those who will claim that a narrow legalistic bureaucratic approach is inevitable in a governmental institution. Whatever the reasons, it is certainly one of the less attractive features of the scheme.

(10) Rehabilitation and Accident Prevention

The adoption of a universal accident compensation plan under the umbrella of one institution provides opportunities for the provision of consistent, co-ordinated and improved rehabilitation services to all accident victims. It also permits a rational and co-ordinated approach to accident prevention. The statistics compiled under such a scheme give a clear picture of accident rates and incidence across all societal activities. Problems can be quickly identified and remedied by a combination of education, incentive or penalty schemes or further statutory regulation.

However, in New Zealand both rehabilitation and accident prevention have been underfunded, and full advantage has not been taken of the scheme's potential as a rehabilitation and safety vehicle.

(11) New Inequities

The implementation of the policy of comprehensive entitlement for all accident victims has in turn created new inequities among the broader class of disabled persons. In New Zealand the accident victim has become a privileged subcategory of the disabled. It is difficult to draw rational distinctions among those who are disabled by accident, by illness and by congenital defects. And yet in New Zealand the benefits paid to the latter two through the welfare system are less

> generous than those paid by the accident compensation scheme. However, the implementation of an accident compensation scheme does not foreclose the possibility of further extension to all of the disabled when it is deemed feasible.

It would certainly appear that many observers agree that the New Zealand accident compensation scheme is far superior to the system it replaced. It provides a much wider range of injured persons with a high level of income maintenance and other more moderate benefits. It provides those benefits, in the large majority of cases, efficiently, quickly and at a very low level of administrative cost. The overall cost of the scheme is moderate and certainly cheaper than retention of the pre-1974 system. Not only does it provide compensation benefits but it also actively assists, encourages and plans the rehabilitation of accident victims, and co-ordinates and promotes accident prevention and safety. The Corporation in carrying out these policies can develop the role of educator and ombudsman in the field.

This conclusion is supported by two commentators who have made a close study of the Accident Compensation Scheme. Mr. William Hodge, Senior Lecturer of Law at the University of Auckland, has written:[9]

> In eight years of operation the system has proven itself. No one wants to return to the bad old days. There is no demand from any quarter to abolish the system.

And according to Professor Ison:[10]

> The new system of accident compensation certainly appears to be a success. It is better than the previous systems operating there and better than any other system known to the writer that is operating elsewhere.

Some concern is expressed, however, about the comprehensive nature of the scheme. Margaret Vennell notes:[11]

> It is argued that neither manufacturers' nor occupiers' lack of care can be adequately policed by methods of prevention largely because facets of accident are so wide; those close to the scene are in the best position to appreciate the likelihood of danger, and the fear of litigation and publicity will generate sufficient awareness so as to guard against breach.

In a paper prepared for the Task Force entitled "Economic Analysis of Fault and No-Fault Liability Systems", Professor Sam Rea highlights the advantages and disadvantages of the system as follows:

> The advantage of the New Zealand system is that it eliminates the overlaps and gaps that arise when coverage is piecemeal. This not only makes the insurance coverage more rational, it also eliminates the administrative cost of allocating accident costs to different sectors. The disadvantages of this general approach are twofold: first, the costs of accidents are not as effectively imposed on those engaged in risky activities, and second, the moral hazard (exaggerated claims) may be greater in some sectors than in others. The efficient response to moral hazard is to provide less generous coverage in situations where the moral hazard is greater or to invest more resources in analyzing claims. The tort system invests substantial resources in determining the magnitude of losses and allocating costs between individuals (or firms) and activities. These two concerns must be weighed against the obvious administrative advantages of having a universal system.

NOTES

[1] Much of the following is drawn from the paper prepared for the Task Force on Insurance by Philip Osborne entitled "A Critical Evaluation of Liability Insurance, Litigation and Personal Injury Compensation: The Lessons and Choices for Ontario".

[2] Woodhouse, "A Critique of the Fault System" in *The Future of Personal Injury Compensation*, a Symposium held at the Faculty of Law, University of Calgary, 1978, p. 8.

[3] Atiyah, "What Now?" in Allen, Bourne and Holyoak, eds. *Accident Compensation after Pearson*, 1979, p. 242.

[4] Fahy, "The New Zealand Accident Compensation System", a paper presented at the Conference on Workers Compensation in Adelaide, South Australia, May/June 1984, p. 7.

[5] Statistics drawn from Reports of the Accident Compensation Corporation.

[6] Id.

[7] Id.

[8] Vennell, "Problems of New Zealand's No-Fault Accident Compensation Scheme", (1984), New South Wales Law Society Law Journal 44, p. 47.

[9] Hodge, "No-Fault in New Zealand: It Works" (1983), Ins. Conn. Jo. 222, p. 230.

[10] Ison, Accident Compensation: A Commentary on the New Zealand Scheme (1980), p. 187.

[11] Vennell, op. cit, p. 45.

APPENDIX 16

THE CURRENT SYSTEM OF DISABILITY BENEFITS IN ONTARIO*

The present system is a shared federal-provincial jurisdiction and can be divided into three classes of programs:

1. The *general disability programs* are those which provide benefits without regard to the cause of disability. They include the C/QPP, private Long-Term Disability (LTD) insurance plans, and social assistance including provincially sponsored programs for disabled persons.

   In Ontario, the Ministry of Community and Social Services provides a monthly cash allowance and other benefits (GAINS-D) to individuals and families in need of long-term financial assistance and to the elderly, disabled, blind, or parents raising children alone. The amount of the allowance varies with the size of the family, ages of the children (if applicable), living circumstances and other special needs. A certain amount of employment earnings is allowed without affecting the cash allowance.

   In addition, recipients of GAINS-D wishing to start full-time employment can receive assistance under the Work Incentive Program (WIN) administered by the Ministry of Community and Social Services. Depending on family size and earnings, qualified applicants may be eligible for monthly cash benefits for up to two years.

2. The *categorical programs* are those which provide benefits to those with specific conditions and/or in limited circumstances. These include the system of provincial workers' compensation programs, benefits for disabled war veterans, the automobile accident insurance system and criminal injuries compensation.

3. There are other benefits and provisions which are of direct importance in assisting disabled persons but which are not directed toward long-term income assistance. These include such programs as Vocational Rehabilitations of Disabled Persons, special income-tax deductions and welfare services.

   In Ontario, certain items of benefit to disabled persons are exempt from provincial sales tax, namely, specified artificial limbs and other prosthetic appliances, orthopaedic appliances, hearing aids and batteries for them, and equipment designed solely for the use of visually impaired or physically handicapped persons. In addition, the purchase of a motor vehicle used to transport someone permanently disabled is eligible for a sales tax rebate, and special arrangements are available to a disabled individual, family member or religious, charitable or non-profit organization providing this transportation. Finally, municipalities can provide such special items as prostheses and wheelchairs to those eligible under the General Welfare Assistance Program.

The strengths of the current system can be enumerated as follows:

- basic protection for almost all earners against total disability through the C/QPP; much higher for individuals covered by LTD;

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* Much of this background is taken from the Main Report of the Joint Federal-Provincial Task Force on a Comprehensive Disability Program (September 1983), with appropriate updating, and references to Ontario.

- good protection against on-the-job injury and automobile accidents;
- provincial assistance programs ensuring a minimum level of income;
- a comprehensive program of vocational rehabilitation services for disabled persons;
- an effective medical care system;
- protection against short-term disability.

Despite these strengths, there are many problems with the current system arising from limitations in individual programs and broad gaps and inconsistencies in the overall protection afforded by the system as a whole. The major problem areas are threefold:

1. **Determination of Disability**

   Because of different objectives, the various programs define "disability" in very different terms. The C/QPP and LTD provide benefits only for total disability. Workers' compensation provides benefits for work-related injury and illness, but it is often difficult to decide whether or not (and to what extent) one individual's illness is work-related.

   Partial disability benefits pose difficult problems in determining the degree of disability. In Ontario, the workers' compensation program uses an estimate of earnings loss, requiring a more active "hands-on" administration.

2. **The Population Protected**

   The existing system has both gaps and overlaps in coverage. The major gaps are:

   - There is little protection for non-earners with the exception of provincial assistance, the legal system and private insurance.
   - The benefits provided by C/QPP are relatively low and payable only in the event of total disability. (Note, however, the recent improvements to CPP benefits involving an increase in the flat-rate disability benefit from $87.56 to $224.40 (1985 rates), thereby raising the maximum CPP disability pension from the current level of $414.13 to $550.87. In addition, the labour force requirements are being eased to include those who have worked for two of the last three years *or* five of the last ten.)
   - Workers' compensation is restricted to job-related disabilities.
   - LTD plans cover only about 43% of the employed labour force and, in the long term, only for total disability.

   Overlapping coverage occurs when a disabled person could be eligible for benefits from more than one program. In most cases, this does not result in excessive benefits because one program offsets the benefits of the other. Thus LTD programs offset any C/QPP benefits and, for example, the recent CPP benefit improvement described above will result in a $17 million reduction in Ontario GAINS-D expenditures. (Currently about 15% of GAINS-D recipients out of a total caseload of 60,000 also receive CPP disability benefits.) In addition, workers' compensation in Ontario integrates or offsets CPP benefits to some extent. Overlapping coverage raises the administrative costs of the system, and duplication of medical forms and examinations is a recurring irritant which frustrates claimants and their physicians. A more integrated, comprehensive system could alleviate these problems.

3. **Adequacy of Benefits**

   (i) While *initial benefit levels* are relatively high for *totally* disabled earners receiving workers' compensation (for on-the-job injuries) or private LTD, the CPP benefit is much smaller and is insufficient on its own to prevent a serious drop in living standards in most cases. Also, workers' compensation and CPP are both subject to earnings ceilings which tend to limit protection for workers with above-average earnings. Provincial assistance programs such as GAINS-D, WIN and GWA are directed at providing for minimum income needs.

Currently, in Ontario, there is a startling and unacceptable discrepancy between levels of benefits under GAINS-D and GAINS for the aged (GAINS-A). As of January 1986, a single person eligible for the GAINS-A guarantee will receive $707.15 per month, while a single GAINS-D recipient receives only $436.00.

(ii) *Inflation provisions* are strongest under the CPP (full indexation) and poorest in LTD plans. Only recently has Ontario tied workers' compensation to increases in the Consumer Price Index, while GAINS-D and WIN remain subject to *ad hoc* provisions only. (Note that GAINS-A is fully indexed.)

(iii) *Special needs* associated with disability are provided for by workers' compensation, GAINS-D and WIN; however, they are ignored under the CPP and only partly taken into account under LTD plans.

APPENDIX 17

THE POTENTIAL EFFECT OF LIABILITY CLAIMS ON THE CANADIAN PUBLIC HEALTH CARE SYSTEM: A NEED FOR LEGAL REFORM AND/OR AN ALTERNATIVE TO LITIGATION FOR THE COMPENSATION OF PERSONS DISABLED BECAUSE OF A MEDICAL MISADVENTURE

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This report reflects the views of the author and not necessarily those of the Department of National Health and Welfare.

Note: The Task Force did not commission this paper, but was made aware of it in the course of the Task Force's activities. In view of the importance of the subject and the analysis therein, the Task Force is grateful to the author for his permission to reproduce the paper in its entirety.

INTRODUCTION

Evidence is accumulating which suggests that the number of complaints made about the medical care received by the public is increasing and that the number of malpractice claims against physicians, hospitals, hospital employees and the health products industries is increasing in Canada.

Furthermore, it would appear that the size of malpractice settlements is also increasing.

Costs to the public health care system are both direct and indirect. Some of the costs are readily identifiable whereas others are not.

Today's true costs may not be known for several years because of the "lag-time" between injury and compensation following litigation.

Much of the evidence that the current litigious atmosphere may be deleteriously affecting our health care system is anecdotal and much is derived by analogy from the U.S. experience in recent years. Concern is being expressed that Canada has begun to follow the pattern that has occurred in the States. Awards and settlements in Canada have now reached the levels of those in the U.S.A. even though Canada provides health care for all citizens. Americans are not as fortunate and a large portion of American malpractice awards must go to pay for the medical care received.

Appendix I

The trend in the Canadian Medical Protective Association (CMPA) fee rates is interesting. The CMPA is a professional liability association to which over 85% of all doctors in Canada belong. Until 1983, the CMPA was able to provide a uniform fee-for-membership to all physicians. Because of a precipitous drop in their excess revenues over expenses in 1983, it was found necessary to carry out an actuarial study of the litigation risks for all types of physicians. As a result, physicians were classified by specialty and the membership fee became dependent on the specialty classification in 1984.

The fee schedule was not increased during 1985 but, because of an increase in the number of malpractice claims and because of the size of awards, it was found necessary to increase it again in 1986.

Appendix II

The escalation in the "Average Award" is plotted on the next graph. The 1984 figure is an estimate because the CMPA no longer publish this statistic. It was necessary to calculate it from data that was available for a 13-month period. If you assume that 12/13ths of the amount is closer to the 12-month average amount awarded, the figure would be $90,000 instead of $101,000. It is interesting to note that the average award in the U.S.A. in 1975 was $94,947 and that in 1984, it was $338,463. The comparison causes some concern as to what the future may hold for this country particularly when it is known that writs have been issued for $15 million and when it is known that awards of $2 million have been handed down in 1985.

Appendix III

The next graph shows the total amounts paid out in malpractice awards or settlements by the CMPA on behalf of physicians from 1971 until 1984. The total amounts paid out by CMPA went from $5.96 million in 1982 to $10.97 million in 1983 and $13.78 million in 1984.

Appendix IV

The next graph shows the legal costs for the defence of doctors by CMPA. As you can see, the legal costs to the society have increased to $7.4 million in 1984.

Appendix V

The next graph shows the revenues of CMPA from 1980 to 1984, together with the projected revenues for 1985 and 1986. Because CMPA is a professional association and not an insurance company, it is not required to set aside large reserves to cover expected losses. Approximately $4 million was set aside in 1984 as a reserve and the rest was paid out in damages, legal costs and administrative costs. The income in 1985 was projected on a basis of the 1984 income since there was no increase in the membership fees. In 1986, there is to be a fee increase which I estimate will increase the revenues to $44 million. My estimate was calculated on a basis of the fee increase, knowing the effect of the 1984 increase and assuming that there was proportionally the same number of doctors in each category. It would seem to me therefore that the cost of "liability insurance" for Canada's 40,000 doctors in 1986 will be approximately $44 million. This, in effect, represents a cost to Canada's health care system for physician malpractice protection. As such costs escalate it can be assumed that it will be reflected in the re-negotiation of provincial fee structures for physicians.

Appendix VI

Can we expect not only an increase in the size of the awards but also in the numbers of awards? The next graph shows a progressive increase in the number of writs served against physicians for 1971 to 1984. Despite the "crisis" which occurred in the U.S.A. in the mid 1970s, there was no corresponding increase in the number of legal actions against doctors in this country. However, Canada began to see an increase in the 1980s. By 1982, 516 doctors were involved in litigation; this rose to "over 700" in 1983 and to 1,266 in 1984. When speaking to the Executive Secretary of the CMPA and to their legal counsel, the expectation is that there will be more than 1,500 doctors involved in new lawsuits in 1985. If you use the 1984 figure, one doctor in 30 was involved in liability litigation. (For comparison purposes, one in 12 doctors was said to be involved in a legal action in the U.S.A. in the same year.)

Appendix VII

The next graph shows the disposition of liability claims for 1978-84. The great majority were settled out-of-court but when action proceeded to trial, few have succeeded. When the Secretary-Treasurer of the CMPA was questioned about the number of settlements, he maintained that it did not imply diminished standards of care but was due to the difficulty their medical advisors had in saying without qualification that care was without reproach. He feels that their medical advisors give the CMPA "expert" opinion and not an opinion based upon the *expected* standards of practice. He said that the usual initial response of their experts, following a review of a case, was that there were no problems with the quality of care provided. However, when asked whether they could support that opinion unequivocally in court in the face of an expert opinion for the claimant, they would then qualify their response. This would suggest that it may be difficult to support a defendant and that it has become more difficult to disprove negligence in the tort system. As medical care becomes more and more complex, it will become increasingly difficult to support a medical act without qualification. If this is so, we can expect that more suits will succeed. In the context of this data, you should keep in mind that the CMPA say that approximately one-half of legal actions against doctors are brought to a conclusion in each year by means of a dismissal, discontinuance without an award, or settlement at the present time.

In the institutional and health products industry sectors, concern is being expressed about the escalation of the costs of liability insurance premiums. Connaught Laboratories and the Canadian Red Cross have had difficulty in negotiating insurance coverage. It has not been possible to obtain insurance for the fractionation of blood products which is done by Connaught for the Red Cross.

Vaccine product liability has become a major issue for Connaught Laboratories in Canada as well as in the United States. Connaught is one of the few suppliers of vaccines in the world and although untoward effects of inoculation are rare, litigation has become a significant problem. If Connaught should withdraw from vaccine production, this country would undoubtedly experience an epidemic recurrence of such illnesses as poliomyelitis. This would result not only in a marked increase in acute and chronic health care costs to the country but also in an impairment of the quality of life of many citizens. The illness cost to the country could be enormous.

The public health units across the country — particularly in Alberta — have experienced difficulty in negotiating insurance coverage. Similarly, volunteer agencies such as the Victorian Order of Nurses and the St. John Ambulance have experienced difficulty in obtaining affordable coverage.

Last year, Gestas, the consortium that has insured both physicians and hospitals in Quebec withdrew from the market. The Quebec hospital sector hopes to keep insurance costs to $8.5 million for the fiscal year 1986 through self-insurance. The $8.5 million figure was deemed necessary because this was the amount that it was going to cost if insurance was to be obtained from the commercial sector. In order to set up the self-insurance fund for hospitals, the Quebec government provided $7.5 million directly.

The Canadian Hospital Association set up a "National Insurance Review Committee" which reported in April, 1986. This Committee has recommended a self-insurance program with a "layer" of commercial insurance in excess of the self-insurance limit. As yet the "limits" of self-insurance have not been established. It should not be forgotten that the authors of the report, Marsh and McLennan, feel that the claims frequency and the cost per claim are expected to increase and that stability will not return to the commercial market in the foreseeable future. They also point out that self-insuring organizations in the United States have experienced the same problems as the commercial insurers. The recent claims experience of the Canadian Medical Protective Association tends to support this statement in this country. Because of funding mechanisms for Canadian hospitals, the source of money for self-insurance comes from the provincial governments and from federal sources through transfer payments.

Currently the clinical pharmacologists in Canada are unable to obtain liability insurance. Other investigators such as the oncologists, gastro-enterologists and cardiologists who carry out clinical trials do not carry liability insurance. Their funding sources are becoming concerned that they do not do so. If economic incentives should be introduced to encourage international pharmaceutical firms to increase their activity in Canada, it would be expected that Canadian research workers would participate. Clinical drug development work carried out under the auspices of a drug house will increase the liability of the universities and the hospitals. It may also increase the liability of the Medical Research Council, the National Cancer Institute and the Canadian Heart Foundation. In the last analysis, if product liability insurance is not obtainable at reasonable rates, it is doubtful that the international pharmaceutical firms can be encouraged to increase their presence in this country, and hoped-for economic gain will not be achieved.

Appendix VIII

The next graph shows the liability coverage statistics for 147 hospitals in Ontario — approximately one-half of the total number in the province. It shows the premiums paid from 1978 to 1985 and the expected premium from 1986. The graph also shows the "losses-to-date" suffered by the insurers and the "expected ultimate losses". The loss-to-premium ratio calculated on the experience to date varies from 102% to 327%. The expected ultimate losses-to-premium ratio is from 465% to 846%. The calculation of the premium for coverage beginning in June, 1986, is on a basis of the ultimate expected loss for 1985, which is $6.9 million, and adjusted for an inflation factor of 30% for 1986. My understanding is that the international reinsuring agents have tolerated low premiums until now in order to be competitive. They have been able to withstand deficits on their premiums because of high interest rates on their investments. However, with the worldwide fall in interest rates, their reserves have fallen and they can no longer tolerate the low premiums which they have charged in the past. Interestingly, they are treating Canada as part of the North American market in the belief that the liability situation in Canada is not significantly different from that in the U.S.A. Another reason for this high inflation factor of 30% is that the average time for malpractice litigation to be settled has increased from three or four years to seven years. Insurance companies are required to maintain reserves against claims made to date, and because the period of time between when a writ is issued and the final settlement has become longer, larger and larger reserves must be maintained; the "long-tail" effect of an increasingly litigious society is making it more difficult for national and international insurers to calculate their actuarial risks.

The question must be asked whether the Ontario statistics for 147 hospitals could be extrapolated to indicate the increased costs of liability insurance for all hospitals across the country. The Ontario Hospital Association suggested that the 147 hospitals for which they had liability coverage statistics were a representative sample of all hospitals in the province. A survey of the Provincial Hospitals Associations and/or the Provincial Ministries of Health was done and it would appear that liability insurance premiums across the country increased from 350 to 1,200%, with a clustering of around 900% in 1986. Since there are 1,029 public hospitals in Canada, it would appear that the cost to the Canadian health care system for increased liability insurance may be in the neighbourhood of $50 million for 1986. It should not be forgotten that the insurance industry expects the escalation in costs to continue.

In a discussion of health care liability, it must be recognized that the legal system is adversarial. When discussing physician liability, the parties to a legal action most frequently include not only the doctor but also the hospital in which the medical act occurred. The majority of medical acts which result in a liability claim occur in hospitals. Because the insuring agent for hospitals is different from the insuring agent for physicians, there is a tendency for hospitals to deny responsibility for the actions of doctors on their staff. This pits the hospital against the doctor and consequently the CMPA has advised their members to refrain from discussing a legal action with the lawyers for the hospital. It should be recognized that it is the doctor who most frequently has the information which would allow the hospital to protect itself but in providing the information to the hospital, the doctor does not have any assurance that the hospital will protect him. It would seem to me that this adversarial approach deflects attention away from the responsibility of society to compensate the patient and the social responsibility of both the doctor and the hospital to maintain and improve standards of care. The adversarial approach induces a "we-and-they" situation which denies the thesis that improved health standards depend upon a team approach by health care professionals and by the institutions in which they work. Because of the threat of litigation to both the hospital and the physicians, peer review and quality assurance programs are not and cannot be effective unless there is a change in the relationship of physicians to the hospitals in which they work and until the reporting responsibilities to the professional regulatory authorities are improved.

I have suggested to you that there is a need for rethinking our present system for the compensation of the medically disabled because of the apparent costs to our health care system. I would also suggest that, at the present time, every Canadian does not have an equal opportunity to be compensated because legal action must be initiated, it costs money and there is no assurance that compensation will be achieved unless negligence is proved.

What are the solutions? I would suggest that there are two:

(1) tort reforms; and
(2) the development of an alternative to litigation for the compensation of the disabled.

TORT REFORMS

Let's look at tort reforms which would be intended to control costs and speed the provision of compensation for the disabled.

Statutes of Limitation: Such statutes are seemingly unpopular in Canada. My understanding is that British Columbia does have provision for Statutes of Limitation and that Nova Scotia is considering them. I, however, feel that they should be carefully considered. If the concept of medical liability litigation is retained, surely physicians, hospitals and the health products industry should not be held accountable for events that have occurred some 20 years ago. The standards of health care have changed and are very different from what they were at that time. According to the CMPA, the third most common cause of malpractice litigation is obstetrical negligence causing brain-damaged infants. Recently there has been an alarming number of legal actions alleging obstetrical negligence as a cause of neurological defects. Some of these claims result from births that occurred in the 1960s. Such actions make it difficult for insurers to calculate their actuarial risks, and for doctors, hospitals and the health products industry to defend themselves.

Collateral Source Payments: The collateral source rule prevents a defendant in a liability action from taking advantage of payments which the plaintiff may have received from another source (e.g., disability insurance, welfare payment, re-training programs, etc.). It has been suggested by Mr. Justice Montgomery of the Ontario Supreme Court that this rule should be re-examined in light of the Supreme Court of Canada's opinion that there is "need to compensate a plaintiff only for his actual loss and to provide for his actual needs".

Subrogated Rights: As with collateral source payments, there is, perhaps, a case for the rationalization of subrogated rights. According to the CMPA, in many malpractice cases, the bulk of the awards goes to satisfy the subrogated claim of a provincial health insurance plan for future health care. As doctors and hospitals are part of the cost of health care system, the payment of such subrogated claims, in the end, is charged back to the health care system.

Lump Sum Settlements: The most common settlement is a lump sum payment. Such settlements usually take into account the income tax that must be paid on the award. This is spoken of as the "tax gross-up" of the award.

Another problem with such awards is that there is no guarantee regarding how such awards are spent. The award may be expended in a short period of time, following which the disabled person may become a charge on the state. Conversely, it may not be totally expended by the disabled person for whom it was intended, and instead will revert to a beneficiary at the time of death.

Structured Settlements: As an alternative to the lump sum settlement, structured settlements have been recommended by such persons as the Chief Justice of Canada, the Honourable Mr. Justice R.G.B. Dickson. Structured settlements may be paid in the form of an annuity which would be tax-free during life. Such a payment could be structured so that there was a periodic review which could be adjusted according to needs throughout life.

Contingency Fees: Until recently, contingency fees were not allowed in Canada. Now, however, 9 out of 10 Canadian provinces allow them, although, most commonly, there is a court review of the reasonableness of the proposed fee. Such fees, however, may amount to 20%-30% of an award.

Pre-judgment Interest: Interest payment may be added to an award from the time an action is brought until the award is made. In a recent $1.9-million award, it amounted to $300,000. It is argued by the insurers, with some justification, that this encourages plaintiffs to prolong the litigation time.

Non-Economic (Pain and Suffering) Awards: Recent *Family Law Reform Act* changes have contributed to the escalation of malpractice awards. Although the Supreme Court of Canada placed a "cap" or a liability limit of $100,000 on such awards, they have escalated to $178,000 in terms of 1985 dollars. Such changes have meant that more family members — not just dependants — are eligible for compensation. Brothers, sisters, parents and spouses of adults who have become disabled have received compensation in recent awards. It would appear that malpractice awards have assumed a different purpose from that for which they were originally intended — the provision of continuing care of the disabled.

AN ALTERNATIVE TO LITIGATION

It would appear that the civil liability system for the compensation of the disabled is cumbersome, complex and expensive. The increasing cost to Canada's health care system is due both to an increasingly litigious attitude of society and to the premium rates changed by international reinsuring companies. Characteristically, insurance premiums have undergone cyclic variations and at the present time they are undergoing inflationary increases. This is expected to continue for the next three or four years, following which a fall in the premium rates may occur. However, it is not thought that the baseline will return to previous levels, and the net result will continue to be an escalation in the cost of liability insurance. Furthermore, the legal system does not ensure that the disabled are compensated unless negligence can be proved. As well, the tort system does not and cannot deal effectively with a health care professional who practices substandard care. Nor can it deal effectively with a negligent hospital, or negligence in the health products industry.

I believe that the issue of the compensation of the disabled should be clearly separated from the issue of the regulatory requirements for maintaining the standards of health care. This leads to the suggestion that an alternative to litigation for the compensation of the disabled be sought.

The idea of a compensation board or arbitration board is not a new one. The role of the compensation board is to determine the degree of functional impairment and to structure a settlement. In the U.S.A. an arbitration board has been suggested. In Sweden and in New Zealand, compensation boards are in place. "No-fault" compensation has worked to a varying degree of success in both countries for over 10 years. In Canada, the Associate Dean of Law of the University of Alberta, Professor Ellen Picard, is a proponent of a "better system for compensating patients". Other respected members of the legal profession have expressed similar sentiments. Mr. Justice A.M. Linden, President of the Law Reform Commission of Canada, has expressed his regret that "patients who deserve compensation may be excluded from it because of the present requirements of tort law" and he has suggested "Canada should consider a social insurance solution".

I believe the compensation board idea should be explored further. In exploring an alternative to litigation for the compensation of persons disabled because of a medical misadventure, tort reform should not be forgotten. Indeed, Section 24 of the Canadian Charter of Rights may necessitate the continuation of the legal liability process. However, a patient could forego his right to appear before "a court of competent jurisdiction" in favour of an appearance before an arbitration board with the assurance that compensation would be awarded according to the degree of functional impairment and not upon whether negligence was proved or not. The advantage to Canadian society and to the public health care system would be that the level and cost of compensation would become predictable. The concept of limited liability will have to be addressed if the universal and accessible health care system is to be preserved and remain affordable.

I would also suggest that the role of regulatory authorities should be strengthened. In the case of the professional regulatory authorities, I feel their role should be strengthened so that they can institute "preventive measures" to maintain standards of practice and, where there is evidence to suggest misconduct, incompetence or negligence, they should be given the regulatory authority to proscribe licences, require re-education and re-certification and, if necessary, they should be able to decertify.

In this discussion, I believe attention should focus upon the primary underlying objectives. In my opinion, these are:

(1) the social responsibility of Canadian society to compensate persons who have become disabled so that they may enjoy a quality of life which would not be attainable if no compensation were available;

(2) the responsibility and accountability of health care professionals, health care institutions and the health products industries to maintain and improve their standards; and

(3) the responsibility of the administrative structure of the health care system to ensure the efficient use of available resources.

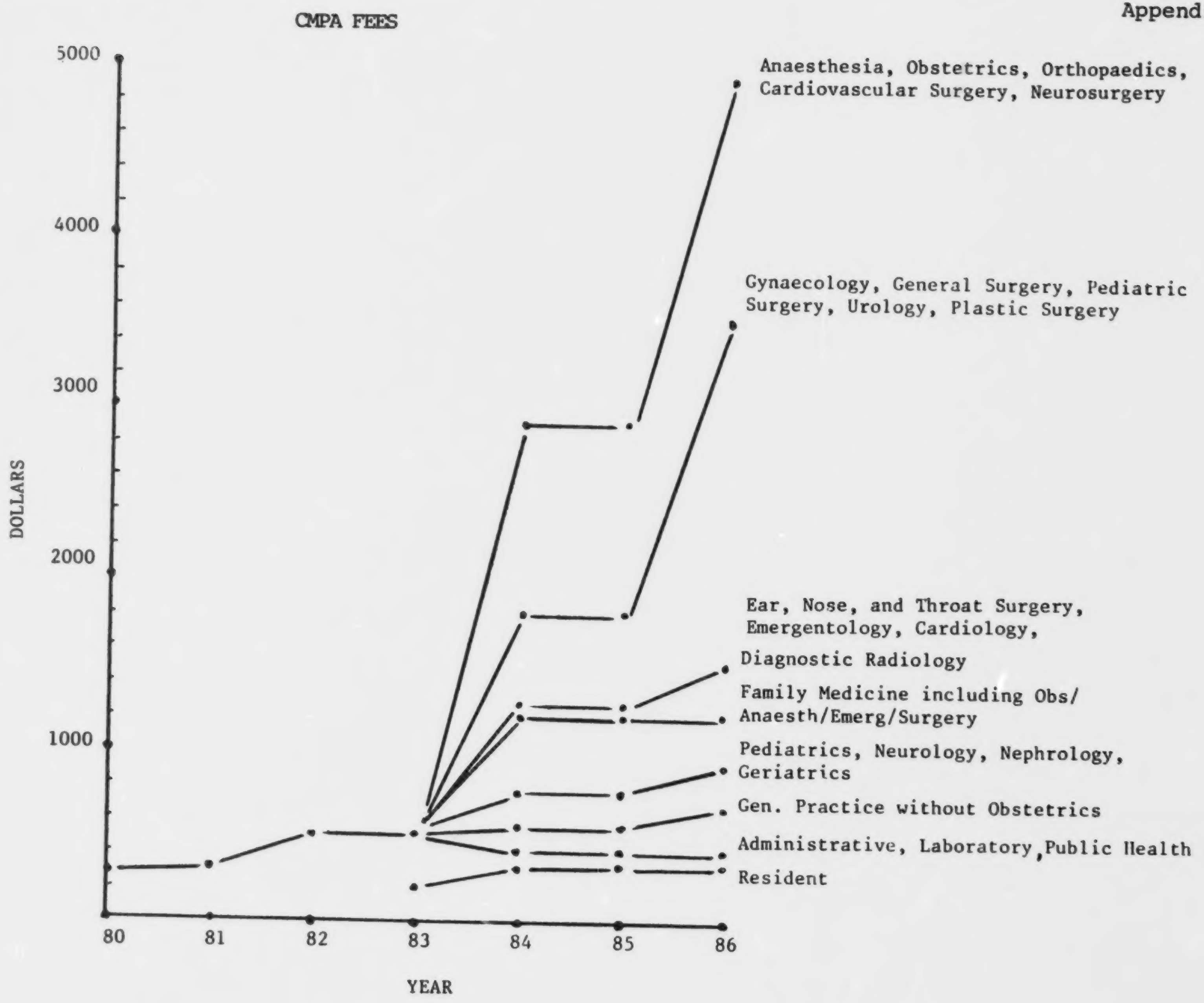
I would suggest that a careful look should be taken at the current legal adversarial approach in order to determine whether it meets these objectives and requirements. If it does not, alternatives should be developed which would complement existing mechanisms and which would be designed to serve and protect both the individual member of society and the public interest.

I would suggest that the problem is not just one of availability or affordability of liability insurance. I would suggest that it is primarily a problem of responsibility and accountability where there is public liability.

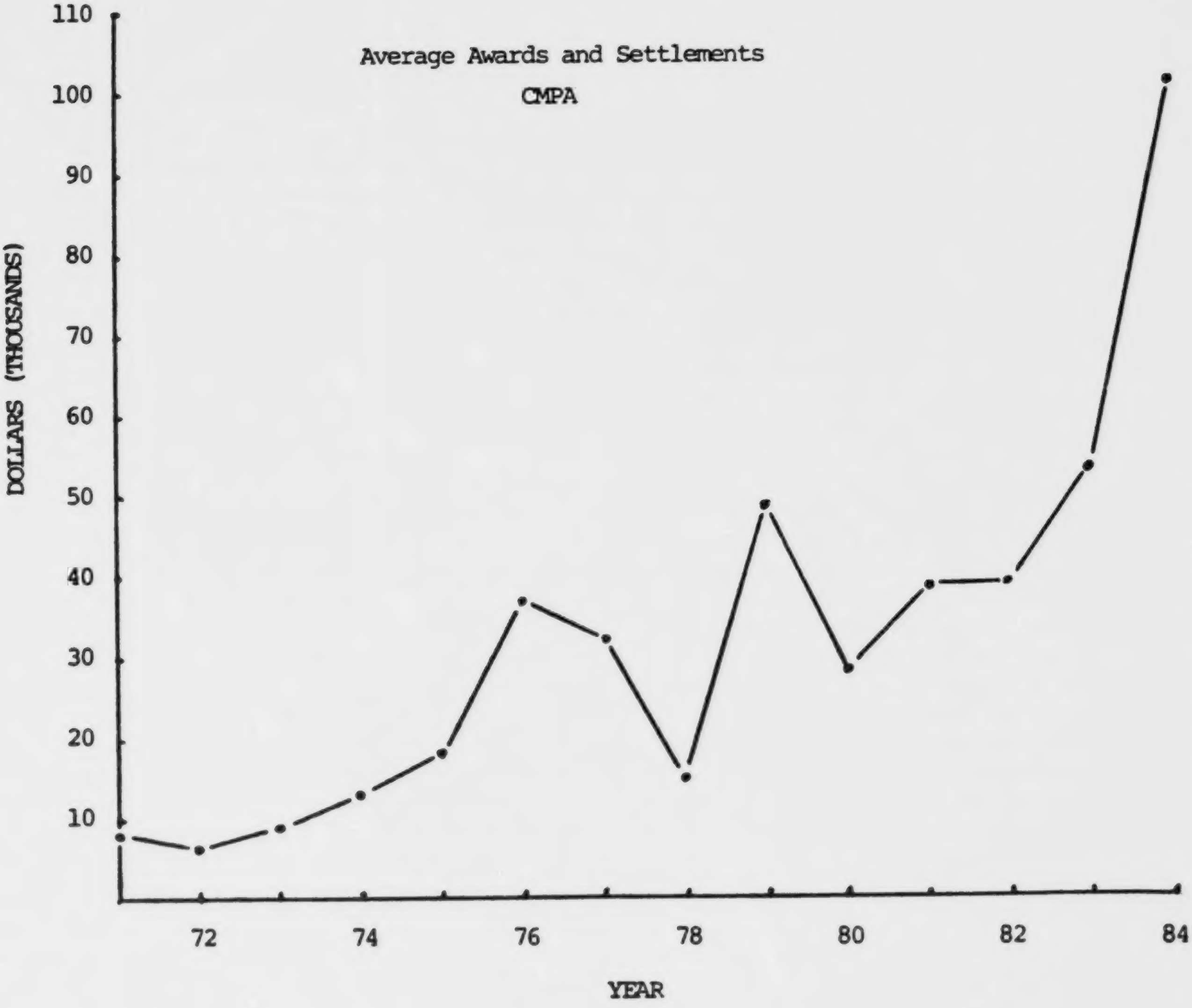
In the context of public liability, the issue extends beyond that of the public health care system. For example, accidents associated with the transportation industry may carry implications relative to the public liability issue. Highway, rail or airplane transportation of hazardous products may result in a liability problem. Regulation may limit this risk but nevertheless it will remain since, of necessity, the transportation of such products will continue. When such accidents occur, it would appear that there should be public liability which will include not only the provision of acute and continuing health care but also the compensation of the disabled persons.

The provision of insurance may be a necessary short-term solution to a current crisis, but a rationalization of public responsibility and accountability should be sought in order to provide a long-term resolution of the issue.

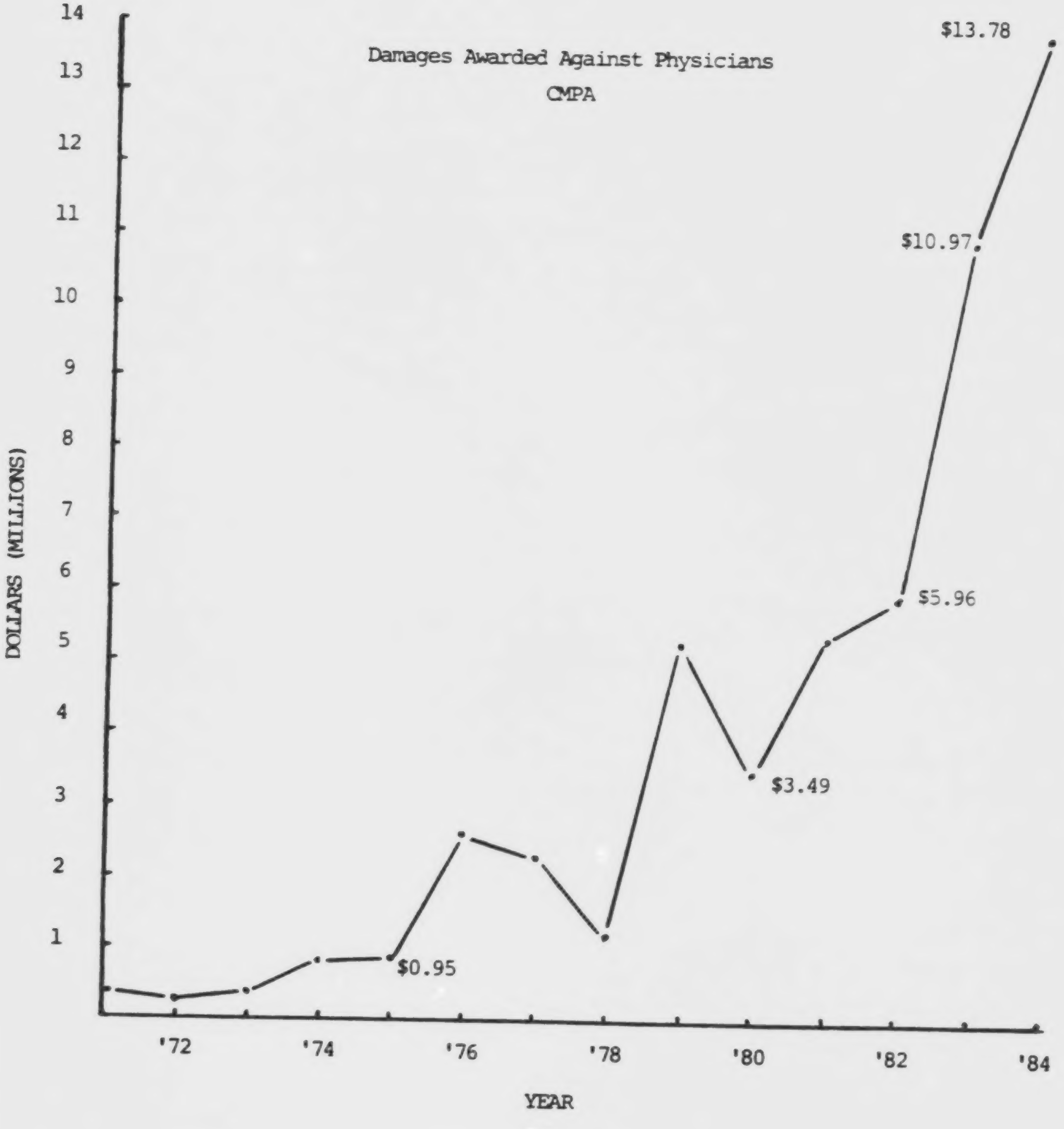
Appendix I



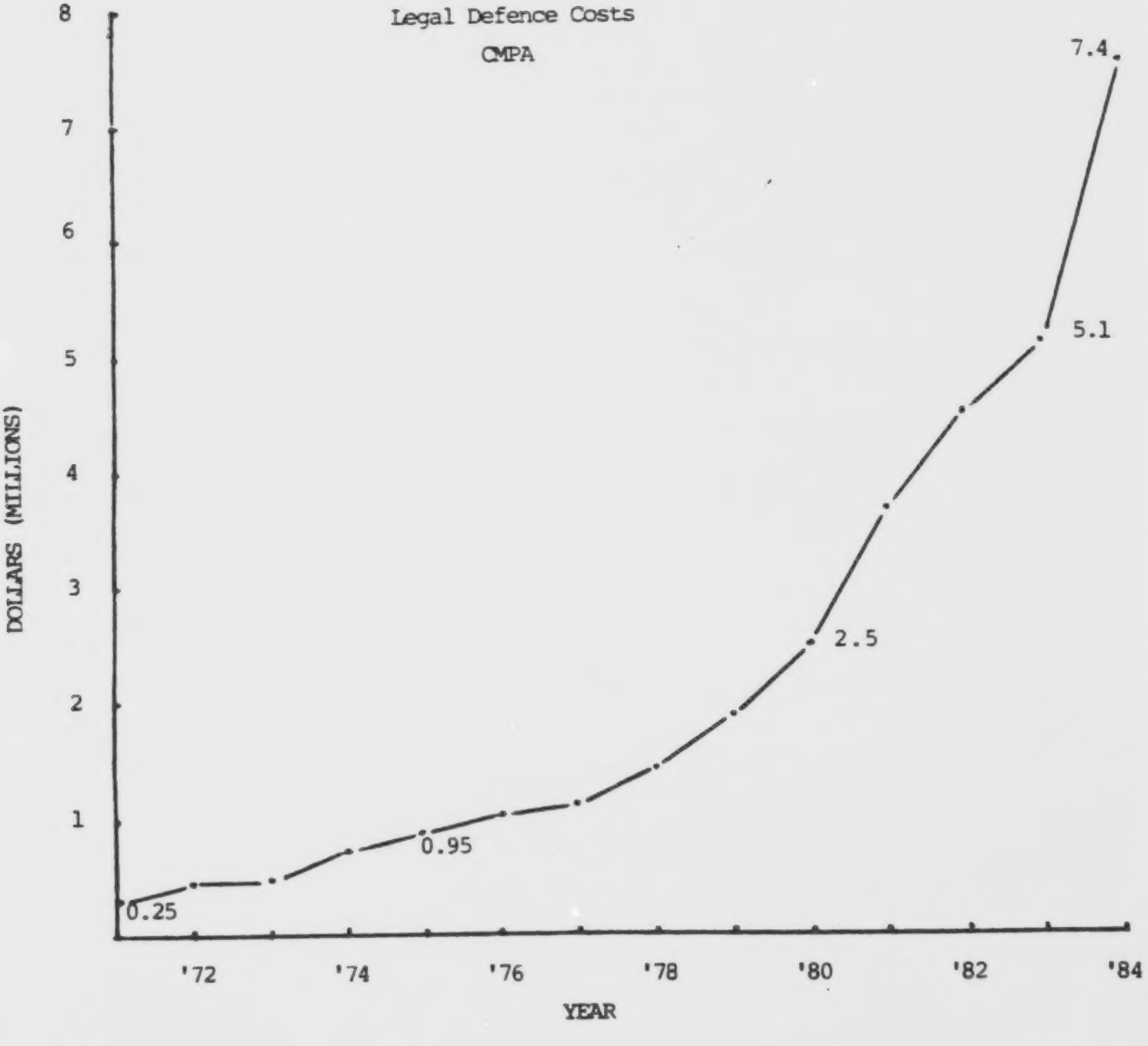
CMPA FEES


110
100
90
80
70
60
50
40
30
20
10
DOLLARS (THOUSANDS)
Average Awards and Settlements
CMPA
72
74
76
78
80
82
84
YEAR

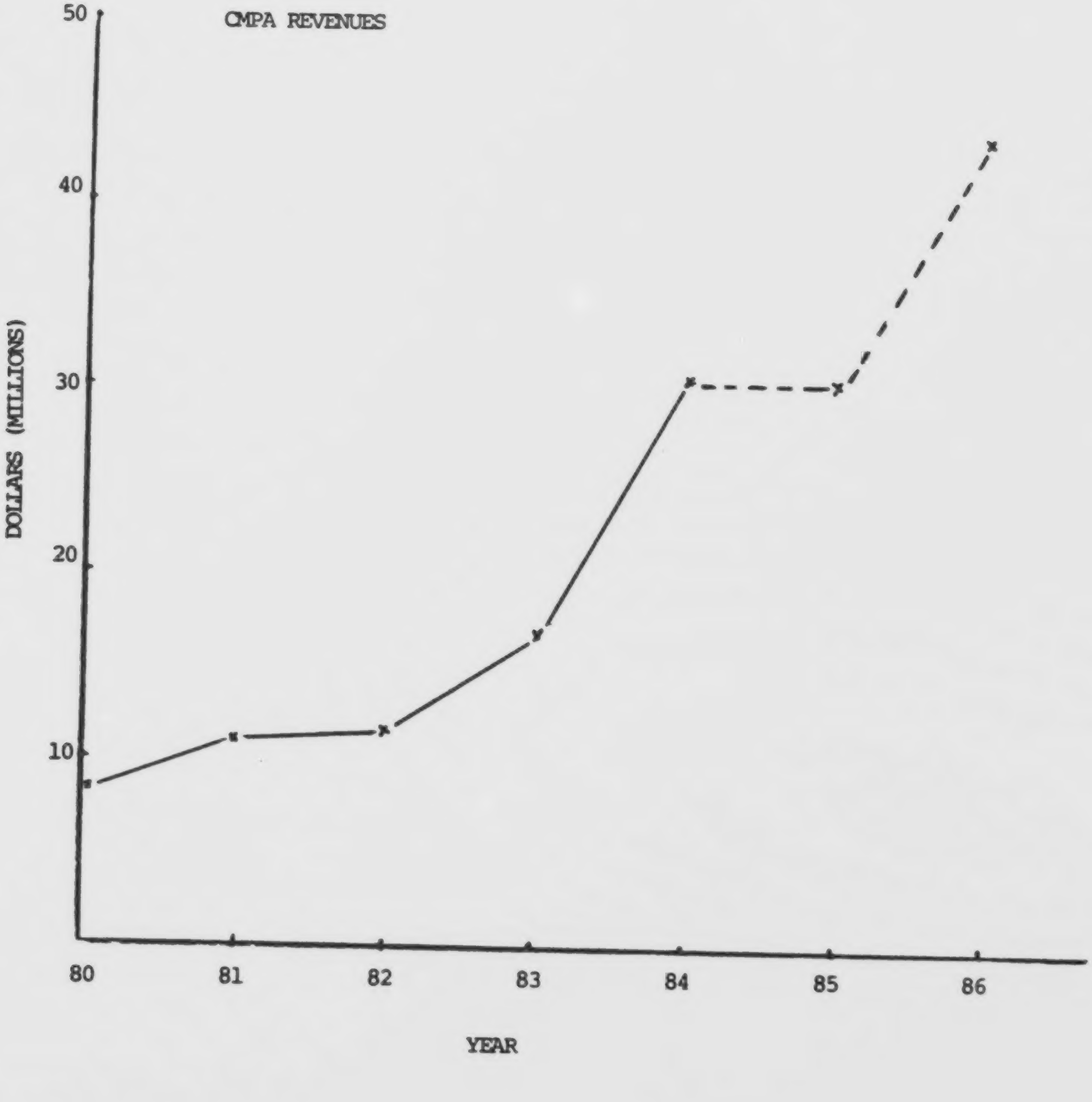
Appendix III



Appendix IV

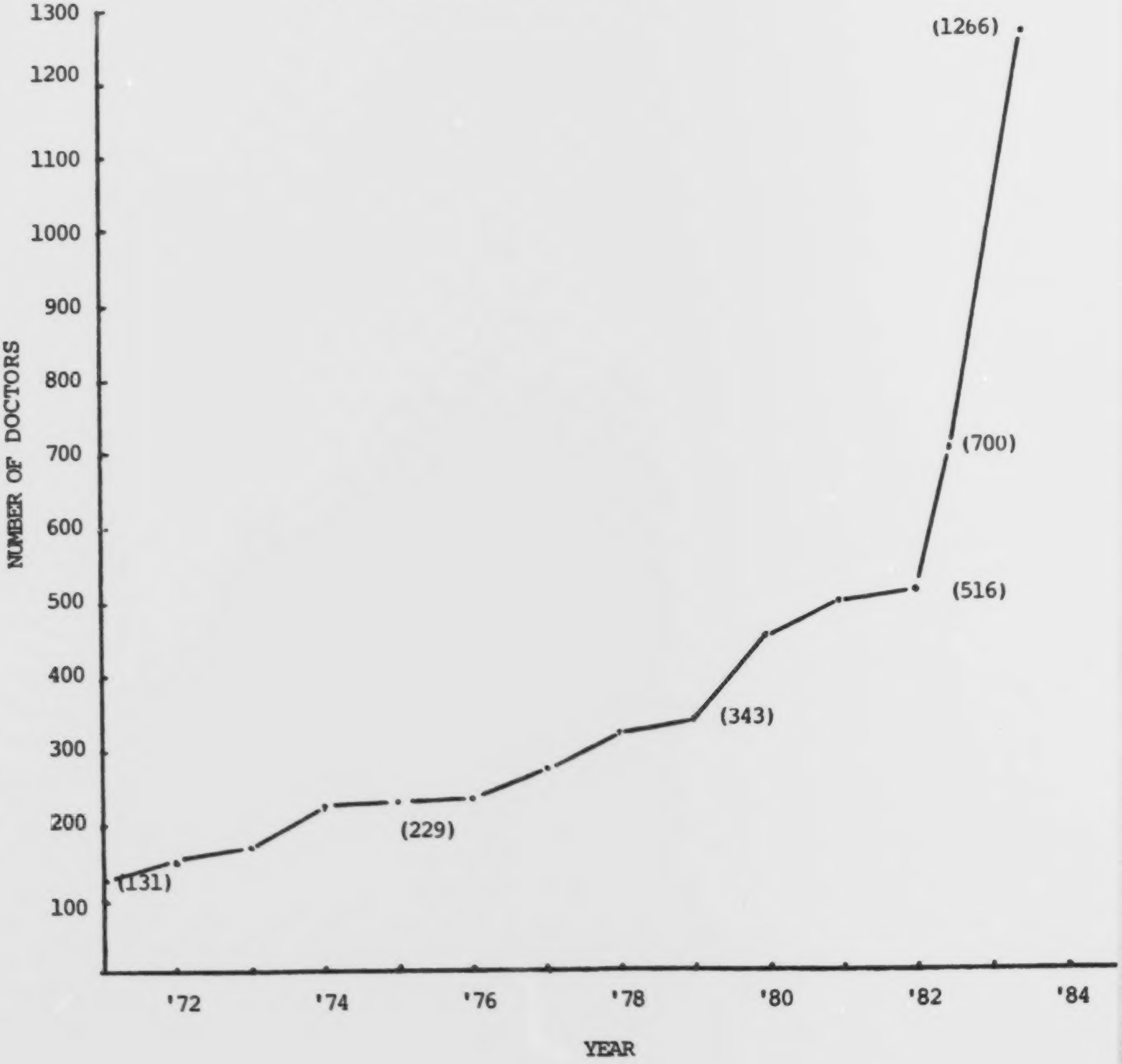

Legal Defence Costs
CMPA
DOLLARS (MILLIONS)
8
7
6
5
4
3
2
1
0.25
0.95
2.5
5.1
7.4
'72
'74
'76
'78
'80
'82
'84
YEAR

Appendix V

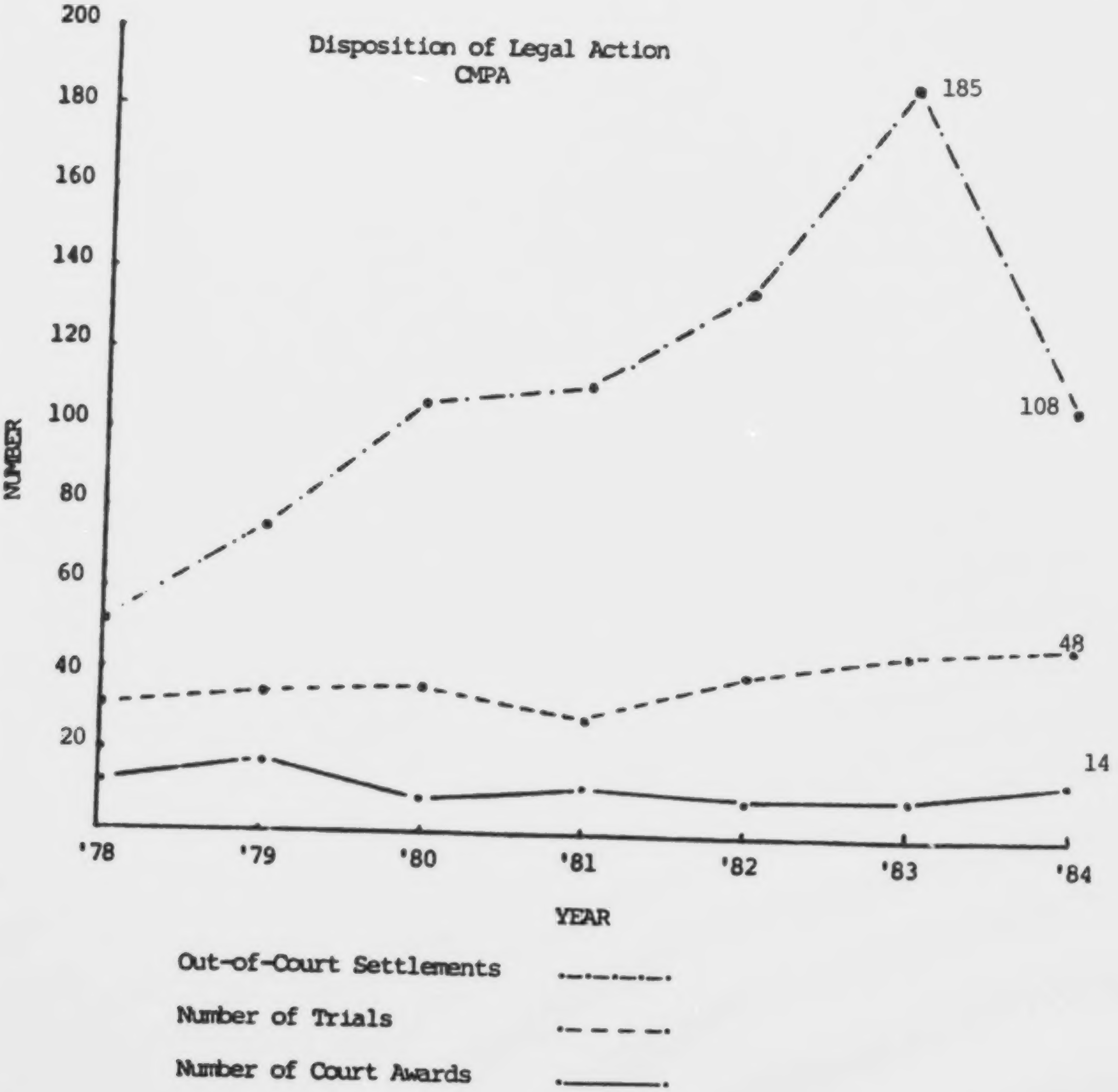

CMPA REVENUES
DOLLARS (MILLIONS)
50
40
30
20
10
80
81
82
83
84
85
86
YEAR

Appendix VI

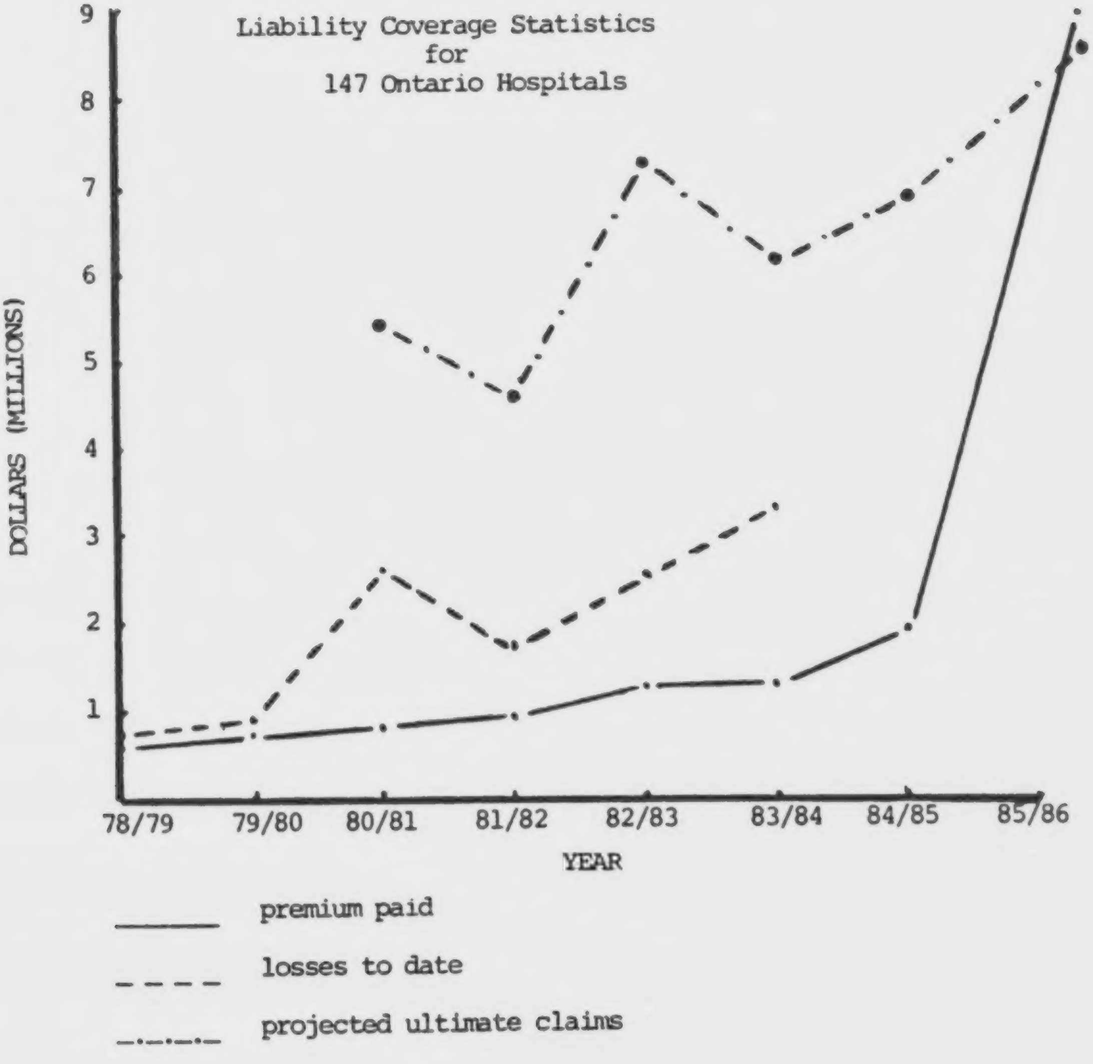
WRITS Served Against Doctors



Appendix VII



Appendix VIII



Liability Coverage Statistics
for
147 Ontario Hospitals

APPENDIX 18

SUMMARY OF PROBLEMS AND PROPOSALS FOR REFORM SUBMITTED TO THE TASK FORCE, CLASSIFIED BY TYPE OF INSURED GROUP OR INDIVIDUAL

The Task Force received about 100 formal briefs and many more submissions from groups and individuals over the course of its mandate. The following material sets out, in summary form, the problems raised and proposals put forward in the briefs and submissions. It does not purport to be in any way comprehensive, and is intended only to indicate the wide range of individuals and groups who have obviously been deeply affected by the insurance crisis and to provide a snapshot of their concerns as presented to the Task Force.

(Note: No reference has been made to the concerns of and proposals put forward by architects and engineers, physicians and surgeons, health-care professionals, hospitals, accountants and lawyers, since these are covered in depth in Appendix 10 dealing with professional liability insurance.)

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Manufacturers, Exporters, Retailers, Wholesalers, Small and Medium-Sized Businesses

Problems

- Affordability and unavailability of liability insurance.
- Huge increases in premiums especially for exports to the United States.
- Most affected producers include: protective equipment, materials handling equipment, machine tools, industrial brakes, cranes, scaffolding, medical equipment and devices, automotive after-market parts, aerospace products, and sports products and clothing.
- Small and medium-sized business more severely affected.
- No insurance coverage for environmental impairment; coverage for sudden and accidental pollution available only from "Spills Bill" pool.
- Lack of meaningful data on products liability experience, etc. IBC's Commercial Lines Statistical Plan less than adequate.

Consequences

- Export operations curtailed; loss of employment.
- Businesses in extreme financial difficulties; some forced to close; increased unemployment.
- Businesses operating without insurance.

Proposals

- Government to establish an export liability insurance program, preferably in conjunction with the federal government. The Government could either assume a portion of the pooled risks or provide limited reinsurance without any element of subsidy to the pool. This would ensure no contravention of the GATT.
- Civil justice reforms as suggested by CBA(O) to moderate size of average awards and settlements.
- Captive insurers, self-insurance for larger commercial entities. This is especially useful for those with large environmental risk exposure and could possibly be made mandatory.
- Pooling of risks among business with common characteristics.
- Claims-made insurance but subject to statutory regulation.
- Improved statistical base. In this connection, the IBC has developed a new general liability statistical plan that will be implemented in the near future. (Note: that the IBC has improved its Commercial Lines Statistical Plan somewhat through additional definitions of the causes of losses and better coding criteria. In addition, new schedule rating was implemented shortly after 1979 which is now represented in the IAO's Rapidscan service.)

Service Providers, Contractors, etc.

Problems

- Affordability and availability of liability insurance and environmental impairment insurance.

Consequences

- Operating uninsured.
- Inability to comply with conditions of contract requiring insurance, leading to loss of business.
- Businesses in financial difficulties; some closing down.

Proposals

- Access to export liability insurance program where appropriate.
- Captive insurers.
- Self-insurance, higher deductibles, etc.
- Government to require the collection of meaningful statistical data to facilitate more accurate rate setting.
- Government to regulate rates and moderate increases.

Directors and Officers

Problems

- Availability and affordability of liability (errors and omissions) insurance. One firm, with no claims history, had its liability limit cut from $75 million to $15 million over two years, and its premiums raised from $60,000 to $650,000.
- In both the United States and Canada, the role of corporate directors has changed significantly. Increased shareholder activism and changes in corporate law and securities regulations, in particular, have resulted in both directors and officers being subject to greater scrutiny and attention. Standard exclusions from D&O insurance are for clearly dishonest conduct, or cases arising from the breach of securities laws, and increasingly, for court actions by shareholders on behalf of the company.
- Directors and officers face an increasing number of suits involving allegations of breaches of occupational health and safety regulations.
- Brokers say there are currently only two main sources of D&O left in North America: American International Group, New York, and Encon Insurance Managers Inc., Ottawa.

Consequences

- Increasing reluctance of persons to serve as directors and officers, leading to a loss of capital and executive expertise.
- Increased cost of insurance passed on to the consumer of the corporation's products or services.

Proposals

- Carrying on business without insurance, but this exposes the firm to considerable financial risk.
- Form a captive insurer (appropriate only for large firms).
- Reciprocal insurance exchange.
- Self-insurance; increased deductibles.

Radio and Television Broadcasters, Print Publishers, News Producers, et al.

Problems

- Affordability and availability of libel and slander insurance.
- Several insurers have withdrawn from underwriting errors and omission insurance (libel and slander). One broadcaster was able to obtain a new policy for a premium of $29,422, subject to a deductible of $25,000 for each occurrence. This represented an increase in premium of 1,950% from the previous level of $1,500.00 per annum, and an increase in deductible from $2,500 per occurrence to $25,000. The broadcaster had never received any notification of libel from any plaintiff and had never been sued.
- High court awards in the United States are usually cited by insurers as explanations for the dramatic premium increases. But a recent Quebec Court of Appeal decision in *Snyder vs. Montreal Gazette Limited* reduced an exorbitant $135,000 award for moral or non-pecuniary damages in a defamation action to $13,500, and it is expected that the Supreme Court of Canada will confirm this effective "cap". Hence, Canadian courts do not appear to be susceptible to the American trends.

Consequences

- Severe financial restrictions leading to the termination of some businesses.

Proposals

- A reciprocal insurance exchange to cover libel and slander exposure.
- Self-insurance
- Improved loss prevention and control.

Municipalities

Problems

- Affordability of liability insurance.
- Availability of insurance for community groups, recreational facilities, etc.
- Availability of insurance for volunteers.
- Insufficient numbers of insurers.
- Annual tendering of insurance contracts to lowest bidder.
- Purchasing property insurance and liability insurance separately.
- Problems in obtaining environmental impairment coverage; coverage for "sudden and accidental" pollution provided by the "Spills Bill" pool is too limited.

Consequences

- Increased taxes.
- Curtailment of recreational facilities, etc.

Proposals

- The preliminary report of the Municipal Affairs Insurance Advisory Committee has put forward the following recommendations:

  1. The Committee recommends that the Provincial Government fund a study dealing with the information provided in the Municipal Liability Insurance Information Survey that would perform the aforementioned tasks and such other tasks as the Committee deems appropriate.

  2. The Committee recommends that the feasibility be determined of establishing a fund that would remove the necessity of purchasing coverage in excess of an operative level of insurance.

  3. The Committee recommends that the Minister of Consumer and Commercial Relations move quickly to establish the Canadian Insurance Exchange.

  4. The Committee strongly recommends that the Attorney General consider municipal concerns, as expressed in a resolution of the Association of Municipalities of Ontario (AMO), when re-drafting the *Limitations Act*. AMO's concerns include:
     - retention of the three-month limitations period for claims based on non-repair of public highways;
     - retention of current notice provisions for claims based on non-repair of public highways;
     - "capping" of limitations period for claims brought by persons suffering a disability at 10 years;
     - exemption from abolition of prescriptive easements for municipalities and public utilities; and
     - no adverse possession of lands vested in a municipality.

  5. The Committee recommends that the Task Force on Insurance consider a revision of the joint and several liability provision in the

Negligence Act that would restore the fundamental concepts of the tort system.

6. The Committee believes that, much like the speed limit signs that are posted at given points in the municipality advising motorists of the limit, unless otherwise stated, signs limiting permission or prohibiting the use of municipal lands, unless otherwise posted, would be as practical as, and substantially less costly than, the current requirements.

7. The Committee recommends that the Ministry of the Environment undertake an information campaign for all sectors of the community to provide a better understanding of Part IX of the *Environmental Protection Act* ('Spills Bill') and the Association Pool.

8. The Committee recommends further investigation in the field of risk management and that educational and promotional programs be made available to the municipal sector, so as to assist in the effective implementation of a risk management program tailored to municipal requirements.

9. The Committee recommends that the Task Force on Insurance consider a similar system for all liability claims, fully recognizing that it may require some time to establish a credible data base upon which to determine an adequate level of compensation.

10. The Committee recommends that a statutory requirement be enacted to establish for municipal insurers a standard system of reporting to the Superintendent of Insurance, similar to that which exists for automobile insurers, in order to provide a consistent statistical base.

11. The Committee also recommends that the Provincial Government, in co-operation with the Association of Municipalities of Ontario and the major municipal insurers, prepare mandatory standard municipal liability insurance policies, which must be used when quoting on all municipal insurance policies.

12. The Committee believes that no further capping of awards is required.

13. The Committee recommends that the Task Force on Insurance consider some form of Good Samaritan legislation that would protection municipal volunteers.

Other proposals

- Appropriate amendments to the *Municipal Act* to require more adequate safety standards and inspections.
- Reciprocal Insurance Exchange.
- Self-insurance where appropriate. Note that Etobicoke, City of Toronto, City of York, Metro Toronto and the Borough of East York have already formed a self-insurance pool. Each is responsible for

liability insurance for claims of less than $10,000 and more than $10 million. The pool then covers them for losses between $10,000 and $10 million.

- Better statistical and data base.
- Possible introduction of no-fault no-tort benefits for accidental injury below a certain threshold.
- Muncipalities to be encouraged to insure both property and liability exposure with same insurer.
- Possible exemption from the *Compulsory Automobile Insurance Act* for municipalities that maintain adequate self-insurance funds for compensation of accident victims. This would be appropriate in the event that a reciprocal insurance exchange is formed that will be subject to regulation by the Superintendent, and can therefore provide the safeguards envisaged by the *Compulsory Automobile Insurance Act*.

School Boards, Colleges and Universities

Problems

- Affordability of liability insurance.
- Availability of insurance for volunteers, sports and recreational groups, etc.
- Availability of insurance for premises where alcohol is served.

Consequences

- Higher taxes.
- Higher tuition fees for colleges and universities.
- Curtailment of sports and recreational activities.

Proposals

- Much more systematic risk management and loss prevention programs.
- Appropriate amendments to the *Education Act* and the *Colleges and Universities Act* to establish adequate safety standards and inspection.
- A reciprocal insurance exchange. (Note that this is now under serious consideration by the Ministry of Education on behalf of the school boards.)
- Civil justice reforms to moderate awards and settlements.
- Increased use of releases by participants in sports and recreational programs and events to limit potential liability.

Day Care Centres

Problems

- Affordability and availability of liability insurance.
- Availability of insurance for volunteers.

Consequences

- Severe financial difficulties; possible closures.
- Carrying on business without insurance.

Proposals

- Much more systematic risk management.
- In-depth review of the standards of care, etc., provided for in the *Day Nurseries Act*.
- Reciprocals; self-insurance.
- Government to continue to support a liability pool, similar to the Facility Association mechanism, to provide residual insurance coverage where none is available in the private market.
- Much better statistical base to provide meaningful loss experience to facilitate premium setting.

Utilities

Problems

- Affordability of liability insurance.

- Availability of environmental impairment and "sudden and accidental" pollution coverage.

Consequences

- Increased cost of insurance passed on to consumer.

Proposals

- Self-insurance; increased deductibles; reciprocals; captive insurers.
- Perhaps mandatory reserves (tax deductible) for major environmental risks.
- "Spills Bill" pool for "sudden and accidental" pollution insurance coverage.
- More emphasis on risk management and loss prevention.

Tavern Owners, Hotels and Motels, Other Business Persons

Problems

- Availability and affordability of liability insurance, particularly in respect of premises where alcohol consumption is permitted, and occupiers' liability.
- Little or no notice of non-renewal, midterm cancellations, or huge premium and deductible increases.
- Unrealistic demands for up-front payments of annual premiums.
- Expanded duty of care imposed on owners with respect to invitees on their property.

Proposals

- Carrying on businesses without insurance.
- Regulation of minimum notice periods for non-renewals, midterm cancellations and increases in premiums and deductibles.
- Self-insurance; increased deductibles.
- Civil justice reforms to moderate awards and settlements.
- Caps on awards.

Agricultural Producers and Processors

Problems

- Availability and affordability of liability insurance, especially for catastrophic property damage.
- Availability and affordability of environmental impairment insurance coverage.

Consequences

- Severe financial crunch.

Proposals

- Expansion of Farm Mutual capacity together with the Government as the reinsurer of last resort in situations such as the greenhouse disaster.

Primary Producers, Processors and Distributors

Problems

- Availability and affordability of liability insurance, especially in respect of environmental impairment and "sudden and accidental" pollution coverage. This affects oil and gas producers, drilling contractors, oil field service and supply operators, chemical producers, pesticide operators, waste managers, transporters of hazardous goods, etc.
- Difficulty in complying with mandatory insurance provisions such as Parts (2), (3) and (4) of Section 27 of the *Petroleum Resources Act*, Regulation 752. This requires a person who is operating a well in a water-covered area to have at least $1,000,000 coverage respectively on damages caused by: (i) the drilling operation; (ii) the production operation; and (iii) the machinery. Other mandatory legislation includes federal and provincial Transportation of Dangerous Goods (TDG) Regulations for a number of specified dangerous goods.

- There is no available insurance for underground storage tanks and industrial dumps.
- Availability of insurance for volunteers and those providing emergency assistance.

Consequences

- Operations continued without insurance coverage.
- Termination of operations altogether, particularly by smaller businesses.
- Borrowing of funds to pay for vastly increased premiums.
- Increased prices to consumer.
- Reduced provision of emergency response services.

Proposals

- Amendment to "Spills Bill" to reduce absolute liability to strict liability.
- Enactment of a variation of Good Samaritan legislation aimed at protecting emergency response teams when they respond to chemical, petroleum, etc., transportation emergencies. A similar recommendation is currently being made by the federal Advisory Council on the Transportation of Dangerous Goods.
- Much greater focus on risk analysis and risk prevention programs undertaken by the insured, in respect of insurance underwriting and rating practices. At the same time, the regulatory apparatus, adequacies of on-site inspections and so forth under the relevant environmental legislation must be reviewed, particularly in respect of hazardous waste management. Municipalities must be encouraged to review and revise anti-pollution by-laws.
- Consideration of an extension of the concept of the "Spills Bill" liability pool in conjunction with the Government as the reinsurer of last resort, to assist in the provision of certain forms of environmental impairment liability insurance.
- Encouragement of Environment Canada's proposal that the Canadian Council of Resource and Environment Ministers (CCREM) convene a working group to examine solutions to the availability crunch. Such groups would include representatives of government, the private sector, insurance brokers, insurers, reinsurers and other individual experts. (See August 1985 proposal for Environment Impairment Liability (EIL) Insurance Project.)
- Provisions for mandatory reserves (tax deductible) for major environmental risks.
- Increased use of self-insurance to be encouraged through appropriate amendments to tax and insurance legislation. Consideration to be given to permitting producers such as oil companies to indemnify members of their sales associate network and other non-affiliated companies in the event that they suffer losses for which insurance protection is either unavailable or prohibitively expensive, e.g., coverage for underground tank leaks and other pollution-related exposures. At present, it appears that this may contravene the provisions of sections 1.30, 1.34, 1.55 and 1.56, and penalties under the *Insurance Act* will be incurred.

Sports and Recreational Groups

Problems

- Availability and affordability of liability insurance.
- Liability insurance costs have risen from 150% to 900% for both provincial and community-based organizations.

- More than 55% of the provincial organizations can no longer obtain participants' liability coverage.
- More than 55% of the municipalities surveyed can no longer provide liability coverage for community groups using public facilities.
- The number of claims filed against provincial sports and recreation organizations over the last three years appears to be less than 10, with the average settlement less than $1,000. (Two recent claims for $3.9 million and $1 million have yet to be resolved.)
- The increase in premium rates and the reduction of coverage has no apparent relationship to the history of claims against the organization concerned.

Consequences

- Severe financial crunch leading to cutbacks on programs or carrying on without insurance.
- Cancellation of sports and recreational activities.
- Inability to attract competent volunteers, staff and card-carrying members.
- The precarious financial position of many sports and recreational groups is described in the brief of the Ontario Sports Medicine and Safety Board as follows:

> Self-generated revenues from registration fees, fund-raising projects, and the sale of technical resources accounts for 35-55% of a typical provincial sport association's operating budget. At the community level this source accounts for 75-80% of their income. The balance is made up of operating grants provided by the Ministry of Tourism and Recreation, and lottery funds provided by the sale of Wintario tickets. The latter two sources have decreased in size over the last five years. This has placed additional pressures on volunteer managers of organizations to either increase their revenues from the other limited sources or to cut back on many of their proven developmental programs.
>
> While a few of the larger and higher-profile organizations have adapted to a tighter economic environment, the majority of the smaller provincial and community groups are struggling just to maintain their basic programs and services.
>
> These organizations are therefore seriously concerned by the turbulence in the liability insurance field and the impact it is having on their ability to continually provide participation opportunities for the citizens of Ontario.

Proposals

- The special committee convened by the Ontario Sports Medicine and Safety Advisory Board to report to the Minister of Tourism and Recreation has put forward the following recommendations:

  - Increased use of releases by participants in sports and recreation events to limit the liability of the sponsoring bodies. The legal validity and use of release forms for majors and minors must, however, be clarified.
  - The concept of a Good Samaritan law to protect volunteers and their respective organizations from legal action must be given serious consideration.

- Risk management guidelines should be developed for volunteer organizations to minimize the inherent risk associated with the activity.
- More stringent guidelines need to be implemented for determining negligence of sponsoring or sanctioning organizations.
- Consideration needs to be given to modifying the *Income Tax Act* of Ontario and Canada to exempt the injured from taxes on court settlements.
- Modifications to the *Family Law Reform Act* should be considered to limit the rights of dependants to claim for damages.
- Pre-judgment interest on settlements can serve as a detriment to early resolution and should be eliminated.
- An independent compensation mediation system, which would remove the dispute from the courts and facilitate a settlement between the plaintiff and the defendant, should be considered for Ontario.
- The practicality and economic feasibility of a no-fault pooled insurance program for sports, fitness and recreation needs to be investigated as an alternative to buying insurance on the open market.
- Limitations on the time period for a plaintiff to initiate legal action should not be extended as they were in Bill 160, 1984.

Other Proposals

- Increased use of self-insurance, such as by Cooper Canada Limited.
- The formation of a national insurance pool for sports and recreational groups, sponsored by the federal Department of Sports. This is currently under consideration.

Volunteer Groups, Charitable Organizations, Cultural Organizations

Problems

- Availability and affordability of liability insurance.
- Premiums totally unrelated to liability risk, loss experience, etc.

Consequences

- Severe financial crunch leading to curtailment of programs, etc.
- Inability to attract competent volunteers, participants, etc.

Proposals

- Some form of Good Samaritan legislation. In particular, the St. John Ambulance brief suggested the following:

> That the Ontario Legislature consider the provision of a "Good Samaritan Law" that would prevent legal action against a person attempting to help another who has received injuries. This legislation exists already in three provinces — Alberta, Newfoundland, and Saskatchewan; however, the previous Ontario government has rejected such action. It would provide protection not only for the 14,200 St. John Ambulance Brigade volunteers as they act as Good Samaritans, but also would provide a valuable social goal of encouraging the over eight million Canadians trained in First Aid and Health Care by St. John Ambulance to help their fellow men. Other health-related volunteer organizations would also benefit from this legislation, including: the Heart & Stroke Foundation, the Royal Lifesaving Society, and the Red Cross.

- Civil justice reforms to moderate awards and settlements.

- Some form of rate regulation or review to ensure that premiums properly reflect the liability risk.
- Improved statistical base.

Entertainment Industry

Problems

- Availability and affordability of liability insurance.
- One rock band's premium for a 55-concert excursion increased from $2,450 to $27,000, an increase of over 1,000% for less coverage.
- Theatres no longer providing insurance to touring companies.

Consequences

- Increased ticket prices.

Proposals

- Self-insurance for theatre owners.
- Captive insurance.
- Civil justice reforms to moderate size of awards and settlement.

Purchasers of Personal Automobile Insurance

Problems

- Affordability; sudden increases in premiums.
- High premiums for young male drivers.
- Too many drivers forced to Facility Association.
- Linking of premiums for close relatives.
- Lack of integrated statistical basis to permit ready access to drivers' records, insurance information, etc.
- Too easy to cancel insurance.

Consequences

- More uninsured motorists.
- Insureds' revolt.

Proposals

- No-fault insurance, for both bodily injury and property damage or bodily injury only.
- Elimination or substantial modification of age, sex and marital status distinctions for setting premiums.
- Government to assist in establishing an integrated data base and to facilitate more efficient electronic access to Motor Vehicle records in co-operation with the Ministry of Transportation and Communications.
- Rate regulation.
- Government insurance.

Purchasers of Personal Property Insurance

Problems

- Household insurance: the homeowners' policy is virtually incomprehensible to the layperson and the industry provides too little information and advice to the public.
- The brief of the Consumers' Association of Canada referred to the following complaints:

> First is the cost. Some years ago, this policy was sold on a three-year basis and premiums were modest. Now, it requires an annual premium, which has been rising every year, out of proportion to any cost-of-living index.
>
> Consumers are confused about the pricing and/or coverage of the auxiliary items in the policy. For example, "contents" coverage is usually expressed as a percentage of the value of the house. Some people complain that their contents are thus greatly

over-valued, not realizing that the figure mentioned does not necessarily represent the true value of those contents, but simply the maximum amount the company will pay in the event of a loss. The "Optimal Loss Settlement" clause, more properly re-named the "Co-Insurance" clause, is also badly misunderstood.

The charge for "outbuildings", or "Detached Private Structures", dismays people who have no separate garage or other structure on their property, while others, who may have several outbuildings, are under-insured.

Consequences

- Source of irritating confusion for consumers.

Proposals

- The Insurance Bureau of Canada, in conjunction with the Insurance Brokers' Association of Ontario, should review the homeowners' policy with a view to simplifying it further for the benefit of all consumers.

Purchasers of Commercial Vehicle Insurance

- Taxis
- Buses, motor coaches
- Trucks, Movers, etc.
- Rent-A-Car fleets

Problems

- Affordability, sudden unjustifiable increases in premiums.
- Poor statistics.
- Sudden midterm cancellations of coverage.
- Too many forced to go to the Facility Association.
- Substantial surcharge for vehicles entering the United States.
- "Spills Bill" legislation.

Consequences

- Businesses in severe financial difficulties; some closing down.
- Substantial interim rate increases for bus fares, etc.

Proposals

- No-fault insurance, for both bodily injury and property damage, or bodily injury only.
- Government to assist in establishing an integrated data base.
- Regulations to be issued prohibiting midterm cancellations and setting minimum periods of notice for non-renewals, premium increases, etc. Many groups and individuals suggest a 90-day period.
- Rate regulation.
- Exemption from the "Spills Bill" legislation with respect to responsibility for environmental restoration.

APPENDIX 19

GOVERNMENT INSURANCE CORPORATIONS

by: David W. Slater

The terms of reference of the Task Force require consideration of the option of the establishment and operation of a government insurance corporation in Ontario. Even if that request had not been specified, any fair-minded consideration of optional structures of general insurance arrangements for Ontario would have to consider such matters, given the operation of well-established government insurance corporations in four Canadian provinces: Saskatchewan, Manitoba, British Columbia and Quebec.

Some Preliminary Distinctions

Before discussing the main question, some preliminary observations about the real matters at issue, as distinct from superficial issues, are in order. The **first** distinction is that, even if a more nearly complete no-fault system is introduced for certain lines of insurance (e.g., for various risks associated with automobiles), it is not at all necessary to have a government insurance corporation to deliver such a program. In many U.S. states where the balance between no-fault and tort approaches to compensation for automobile accidents is tilted further toward no-fault than in Ontario, delivery is through private insurers. **Secondly**, while there are some generalizations which apply to government enterprises in any or all lines of insurance, many issues are product specific. The pros and cons, the problems and issues are somewhat different for government programs related to bodily injury arising from the use of automobiles than they are for programs dealing with property damage, and different again for various lines of liability insurance. Broadly speaking, government insurance corporations in Canada (aside from workers' compensation) have achieved a higher degree of success in insurance against occurrences of bodily injury from the use of automobiles, and a lower degree of success in general liability and casualty insurance, with some other lines falling in between these extremes.

The **third** distinction concerns good and poor performance of government enterprises. Among government enterprises in Canada, there are and have been both good performances and poor performances judged by tough economic and social criteria. There are strengths as well as inherent weaknesses in the use of the government enterprise form of organization, but there are inherent weaknesses in private enterprises too. If government enterprise is the chosen vehicle to carry on some activity (e.g., telecommunications services, electricity generation and distribution, fundamental scientific research), then it is important to obtain good performance rather than mediocre or bad performance. That goal involves arrangements to overcome or limit some of the general weaknesses of the government enterprise form of organization. But it also involves specific criteria and arrangements appropriate for the line of activity carried on. From observations of the performance of government insurance corporations in Canada, a number of guidelines emerge to which Ontario should pay attention if it chooses to use a government insurance corporation to carry on some lines of property and casualty insurance.

The **fourth** distinction is that even if the government enterprise form is used for some property and casualty insurance activities in Ontario, it is highly probable that much of such insurance activities will continue to be carried on by private arrangements, albeit regulated by governments.

General Issues Regarding the Use of Government Enterprises for the Production and Distribution of Goods and Services in Canada

Government enterprises, even when they have a strong commercial mandate, are almost always expected to carry out some "social missions". A government telephone company is expected to provide cheap service to remote areas or to elderly citizens and to cover the extra costs out of the rates for other services. A government airline is expected to provide services to remote areas, covering the extra costs out of rates charged for services in dense traffic patterns. An electricity generating and distribution corporation is expected to provide cheap power to industry in remote areas to promote regional development, recovering the subsidy from rates in prime markets. A government enterprise is expected to be a model in affirmative action programs to promote important social goals.

That government enterprises have mixed objectives is a fact of life; it has always been so and will likely continue to be so. But that makes it difficult to evaluate the commercial effectiveness of government enterprises. The personal belief of the Chairman of the Task Force is that there is almost always a tendency toward a creeping expansion of the social objectives in competition with the commercial objectives in government enterprises. It is essential that, if Ontario is to embrace government enterprise for some insurance activities, it make explicit and then evaluate the success and cost of achieving the social missions which will be attached to such an activity. It must also find ways of reconciling the social and the commercial missions which such a corporation might be given. Such guidelines and results must be stated clearly and be available to the general public, as accountability to the public is critical.

Government enterprises have to be accountable to the public through governments. Both good and bad consequences follow from that fact. On the "good" side, there is greater openness of accountability and better evaluation of social performance in government enterprises than in private ones. On the "bad" side, short-term political expediencies often are given a heavy weight. Ministers hate to admit that something for which they are responsible has performed badly. The search for debating points is continuous: favourable ones for a government, unfavourable ones for the opposition. Also found on the bad side is the tendency toward a bureaucratic mind-set of the controllers and middle management of government enterprises.

If the Government of Ontario uses the government enterprise form for some general insurance activities, it will be extremely important that tough-minded independent accounting and actuarial audits be carried out, and the medium- to longer-run performance of the enterprise be examined periodically by select committees of the legislature.

Government enterprises, even if only marginally "in the black", tend to be perpetuated, though by any reasonable comparative standards of effectiveness in the use of capital they may be poor performers. There is a much greater tendency even for government enterprises that are "in the red" to be kept alive than for private enterprises.

Government enterprises generally do not pay corporate income taxes, either federally or provincially, although there are exceptions. The tax advantage of government enterprises over private ones, however, should not be exaggerated, because most business corporations pay rather little corporation tax, despite the appearance of taxability as judged by the textbook story of tax rates.

Specific Insurance Issues Regarding Government Insurance Corporations

In their commercial operations, government insurance corporations have evolved into being more alike than different from private insurers. They undertake to pay a set of future claims to be established by experience; they collect premium income in advance; they earn investment income on their reserves and on the funds built up from premium income being received in advance of payments of claims; they incur the same kinds of transactions costs, though perhaps on a different scale from private insurers; they engage in reinsurance activities.

How may they differ from private insurance corporations? **First,** the bottom line for government insurance corporations is usually the requirement of breaking even, of showing no profit. As already noted, none of them pay corporate income taxes, federally or provincially. In fact, all of the government insurance companies in Canada aim to be moderately profitable and to retain the profits in the corporation. This practice has arisen among the companies in Western Canada, after each experienced losses that had to be met by the infusion of capital from their governments. Accordingly, each aims to avoid going back to its government for further infusions of capital. The only way to avoid such a situation is to build up capital within the corporation, usually under some such heading as a rate stabilization reserve. On average, those reserves are intended to grow, which can only happen if, on average, premium plus investment income exceeds claims paid plus contributions to claims reserves plus transactions costs.

The policy issues for Ontario, if it opts for a government insurance corporation, are as follows: What initial capital is to be put into the corporation? What investment policy is to be pursued by the corporation? What profit targets and retained profit policy is to be followed? What (if any) return is to accrue to government from the profits of the corporation? And, finally, if the rules allow the corporation to accumulate profit, how will that be done and what will be the rules governing a rate stabilization fund if one is established?

A **second** possible difference is in the time-horizon over which premium adjustments may be made. For La Régie de l'assurance automobile du Québec, premium adjustments have been more gradual than in comparable private sector auto insurance for bodily injury. La Régie appears to take a medium-term horizon in determining and adjusting its rates. There has also been somewhat greater stability over time in automobile insurance rates for the other government insurance corporations than is typical for the private industry in Canada. It is not at all clear that the average changes over time are all that different when the factors in each government corporation are made comparable, but short-term variations in premiums appear to have been smaller for the government corporations. This must reflect a somewhat longer horizon in rate management.

A **third** difference is that each of the government insurance corporations carries out some "social missions". These missions are often rationalized as the *quid pro quo* for the grant of a monopoly, or for the non-profit, non-taxable treatment of the corporations by their government owners.

A **fourth** difference is alleged: that is, that the transactions costs of government insurance corporations are lower than their private sector opposite numbers. This implies that a larger proportion of the revenue dollar (premiums plus investment income) will find its way into claims paid than in private insurance corporations. In evaluating this contention it is important to compare "apples with apples", but it is very difficult to do. The book of insurance business differs among the government insurance corporations and differs from that of many individual private insurers in Ontario. No-fault compensation arrangements differ. Attitudes toward suing people appear to be different in Manitoba and Saskatchewan than in British Columbia and Ontario. Distribution and commission arrangements differ. The considered judgment of the Chairman of the Task Force is that for comparable insurance transactions, particularly for compulsory automobile insurance, the transactions costs of the government insurance corporations have taken a somewhat lower proportion of the revenue dollar in recent years.

A **fifth** difference is in the management of the investment portfolio of the government corporations. All of them have substantial investment portfolios, mainly arising from claims reserves, unearned premiums and other reserves. In Manitoba and Saskatchewan, the investment portfolio is specific to the corporation, but managed by the provincial treasury. There is a bit of a bias toward investment in municipal and school board securities from within the province, and provincial government and utility debentures. In British Columbia, the ICBC manages the investment portfolio itself, but again with a bit of a preference for provincial bodies or subordinates, including municipal financing. In Quebec, the portfolio is part of a Caisse du dépot pool, managed by the Caisse du dépot.

For all four of the government insurance corporations, there thus appears to be a bias in favour of the securities of provincial governments or their subordinates, and less than usual basket clause investment in private property or equities, as compared with private sector general insurance companies.

If Ontario were to go the route of a government insurance corporation, it would have to decide what the reserve policy is to be, who is to manage the investment portfolio, and what guidelines are to be imposed on the portfolio management. In my view, the primary objectives in the management of such a portfolio should be the safety of and the benefits to insureds, rather than the financial ease of the provincial governments or their subordinates, such as crown corporations or municipalities.

Specific Activities of Government Insurance Corporations

Government insurance corporations have been most successful in basic bodily injury and property damage coverage related to the use of automobiles. The basic coverage for both of these is a government corporation monopoly operation in Manitoba, Saskatchewan and British Columbia; in Quebec the monopoly is limited to bodily injury. The governments have turned out to be relatively efficient providers of these basic insurance services. In Quebec, while the government corporation is not in the property damage business, the government has animated the development of the Groupement des assureurs automobile as a co-operative private sector vehicle which in turn has some responsibility for the Quebec version of the Facility Association.

All three of the western government insurance corporations have eliminated rate classifications based on age, sex and marital status. All have some version of adjustment of insurance premiums on the basis of accident and driving infringements. The British Columbia system has the steepest penalty increments, which are fully integrated with a comprehensive data base on accidents, infringements, licence status and insurance.

The three western government insurance corporations have all been in the non-auto general insurance business at one time or another, but British Columbia has recently sold off this part of the ICBC operations. The general insurance business has been a less happy experience for government corporations and their government owners than the auto insurance business. The Saskatchewan corporation has been in the general insurance business since the end of World War II, aiming to meet the special needs of Saskatchewan, particularly, of rural Saskatchewan, which it was alleged were either not being met or only being met at exorbitant rates by private insurance organizations. In general, the business has not met its costs easily. The government corporation has been expected to cover difficult risks at low rates. Reinsurance, both in ceding and accepting, has been an unstable experience, at times involving substantial losses. The Manitoba Insurance Corporation was asked to take on difficult pieces of general insurance business in the hard market cycle of the 1970s; it, too, has had a rocky road in covering its costs, and has had losses in the reinsurance business. It is now trying to develop a more balanced portfolio of non-auto business, mainly in personal lines, in competition with the private insurance companies. It is also trying to balance the financial position of its general insurance activity by integrating the optional auto insurance business.

APPENDIX 20

THE FUNDAMENTAL IMPROPRIETY OF INCOME TAX ON PROCEEDS OF LUMP SUM SETTLEMENTS FOR COSTS OF CARE: SIMPLIFIED MODEL

By: David W. Slater

1. The central proposition is that, if a flow of future revenue to cover future costs of care is not subject to income tax, then neither should the flow of revenue derived from a lump sum settlement (intended to provide that flow of future revenue) be.

2. Suppose that the future care costs are represented by AB in Figure 1, for period t_o to t_n, and are intended to be non-taxable; and that the inflation escalation is at x% per annum.

3. Suppose that the present value of the future care costs, discounted at a tax-free rate of $(x + y)$% per annum, yields a lump sum at t_o of S_o.

4. Suppose that the revenue stream from S_o is CD in Figure 1, with OC being initially larger than OA, the difference being used to build up a capital sum; similarly for year $t_1, t_2, \ldots t_m$. Gradually, the revenue stream and the care costs stream will approach each other, and then cross over.

5. Up to $t = t_m$, the capital sum will build up; thereafter it will decline. Over the actuarial expected life of the arrangement, the cumulative increment of wealth (i.e., the capital sum) will be zero.

6. The cumulative increment of wealth equals zero. The cumulative increment of wealth is, by definition, equal to the cumulative of income over the period, which then is also equal to zero.

7. The integral of the excess of the revenue stream over the costs stream to $t = t_m$ equals the integral of the excess of the costs stream over the revenue stream between $t = t_m$ and $t = t_n$.

8. Since there is no income over the life of the arrangement, there should be no tax over the life either.

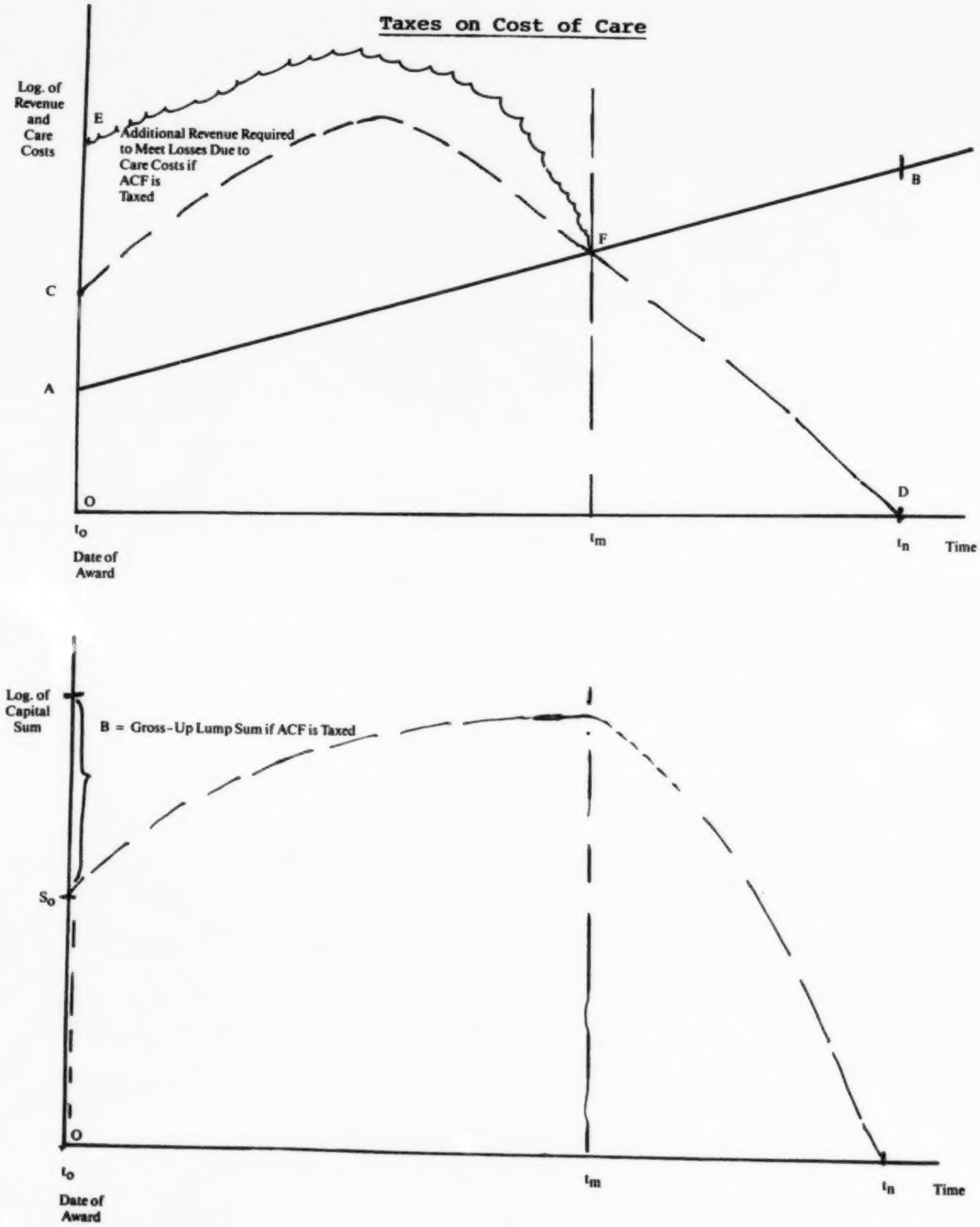
9. If the tax authorities treat the excess of the revenue stream over the tax stream in the early years of the arrangement as income for tax purposes, but do not provide refundable transferable tax credits for the period when the revenue stream is less than the costs stream, then they are imposing a net tax over the life of the arrangement, even though there is *no* net income and *no net increment of wealth*.

10. Gross-up is based on the practice set out in number 9. This is a fundamental error in the application of personal income tax. The stylized result is to require a grossed-up income stream EF to yield the after-tax revenue stream CD, and requires a lump sum payment of B, grossed-up from A.

11. Tax should *not* be imposed at all; nor should gross-up, if appropriate definitions of income are applied for tax purposes.

Figure 1

Taxes on Cost of Care


Log. of Revenue and Care Costs
E
Additional Revenue Required to Meet Losses Due to Care Costs if ACF is Taxed
B
F
C
A
O
D
t_o
Date of Award
t_m
t_n
Time
Log. of Capital Sum
B = Gross-Up Lump Sum if ACF is Taxed
S_o
O
t_o
Date of Award
t_m
t_n
Time